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ABSTRACT

A search of requests for permission to photocopy articles from past issues of "Zero to Three" identified the seven articles of this collection, all published between 1985 and 1989. They deal with the care of typically developing infants and toddlers as well as with clinical practice with very young children with special health or developmental needs and their families. The seven articles are: (1) "Helping Young Children Channel Their Aggressive Energies" (Sally Provence); (2) "Parenting an Infant with a Birth Defect: The Regulation of Self-Esteem" (Dorian Mintzer, Heidelise Als, Edward Z. Tronick, and T. Berry Brazelton); (3) "The Immediate Impact of the Birth of a Low Birth Weight Infant on the Family" (Alan R. Fleischman); (4) "Infant-Parent Psychotherapy with an Autistic Toddler" (Barbara Kalmanson and Judith H. Pekarsky); (5) "Infants and Toddlers in Hospitals: Addressing Developmental Risks" (Joy Goldberger); (6) "Mediating Successful Parenting: Guidelines for Practitioners" (Serena Wieder); and (7) "The Developmentally Designed Group Care Setting: A Supportive Environment for Infants, Toddlers and Caregivers" (Louis Torelli). A topical index groups articles and reviews of publications that appeared in "Zero to Three" from September 1980 through June 1992 by topic. (SLD)

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- developing a broader understanding of how services for infants and toddlers and their families are best provided; and
- promoting training in keeping with that understanding.

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Table of Contents

3 1. Helping Young Children Channel Their Aggressive Energies—Sally Provence, M.D. (April, 1985)

7 2. Parenting an Infant with a Birth Defect: The Regulation of Self-Esteem—Dorian Mintzer, Ph.D., Heidelise Als, Ph.D., Edward Z. Tronick, Ph.D., and T. Berry Brazelton, M.D. (June, 1985)

15 3. The Immediate Impact of the Birth of a Low Birthweight Infant on the Family—Alan R. Fleischman, M.D. (April, 1986)

20 4. Infant-parent Psychotherapy with an Autistic Toddler—Barbara Kalmanson, Ph.D. and Judith Pekarsky, Ph.D. (February, 1987)

27 5. Infants and Toddlers in Hospitals: Addressing Developmental Risks—Joy Goldberger, M.S. (February, 1988)

34 6. Mediating Successful Parenting: Guidelines for Practitioners—Serena Wieder, Ph.D. (September, 1989)

37 7. The Developmentally Designed Group Care Setting: A Supportive Environment for Infants, Toddlers, and Caregivers—Louis Torelli, M.S. (December, 1989)

Zero to Three Classics

Introduction

When we began planning to offer a collection of articles from past issues of *Zero to Three* as an incentive to new subscribers, we faced a daunting dilemma—how to choose among the dozens of articles that we have had the privilege of publishing since *Zero to Three* began, in September, 1980?

We decided, finally, to look in our files of requests for permission to photocopy articles from *Zero to Three*. These requests come most often from instructors in a wide range of undergraduate and graduate training programs; they also come from front-line practitioners and program planners who wish to distribute relevant articles at inservice training sessions or professional conferences. A selection of most frequently requested articles, we reasoned, would be likely to reflect the interests of our diverse readership.

The seven articles included in this collection were published between 1985 and 1989. They deal with the care of typically developing infants and toddlers as well as with clinical practice with very young children with special health or developmental needs and their families. Authors include a child care consultant, a child life specialist, a neonatologist, two pediatricians, five psychologists, and a special educator.

Readers who find this selection of *Zero to Three* classics useful are invited to consult the topical index to volumes I through XII of *Zero to Three*, included at the back of this publication, and to use the enclosed form to order back issues of particular interest. In addition, the *Zero to Three Child Care Anthology* includes 16 articles, on all aspects of infant/toddler child care, that were published in *Zero to Three* from 1984-1992.

Emily Fenichel
Editor
August, 1992

1

Helping Young Children Channel Their Aggressive Energies

Sally Provence, M.D.

Ask any parent whether she wants her child to be an aggressive person and you are likely to get more than one answer. After all, aggression is associated with both approved and disapproved behavior in our minds and in our society—both with the energy and purpose that help us to actively master the challenges of life and with hurtful actions and destructive forces.

Most of us want our children to be able to take a stand for themselves when others treat them roughly. We hope that they will not start fights but if attacked will be able to cope with the attacker and not be overwhelmed. A child's learning to find a healthy balance between too much and too little aggressive behavior is probably the most difficult task of growing up.

According to developmental theory, aggressive impulses or drives are born in the human child and are a crucial aspect of the psychological lifeforce and of survival. In the course of healthy development, these drives are normally expressed in various behaviors at different ages and, with assistance from parents and others, are gradually brought under the control of the individual—moderated, channeled and regulated but by no means stamped out. We expect that young children who are developing normally will display aggressive behavior—both physical and verbal—toward adults, other children, and objects in their environment. Brothers and sisters engage in combat. Young children in groups inevitably behave aggressively toward one another just as they behave in friendly ways and join in interesting activities. When they want the same toy or the same adult, competition and strife are bound to occur. If a child is irritable or angry, he or she may lash out at another without apparent provocation.

During the first year, infants are not often thought of as behaving aggressively, and yet encounters in which an infant pushes, pulls, or exerts force against another are signs of the outwardly directed energy and assertiveness that reflect the healthy maturation of aggression. But the nine-month-old who pulls your hair does not know that it might hurt—it is done in the same exuberant, playful spirit that is seen in other activities. It is only in the second year, when the child develops a better awareness of his separateness as a person—of "me" and "you"—that he can begin to connect his actions with some kind of result and can begin to understand that he is angry at someone and behave with intentional force.

We do not usually talk about a child's being cruel or hostile toward others until some time during the second year. Even then, he does not know enough about cause and effect to understand the consequences of his action or how to regulate his behavior toward others. When your fifteen-month-old smashes a fragile object, he is caught up in the pleasure of assertiveness, not anticipating its result.

Parents sometimes tell me about their toddler who "knows better" than to hit or bite. They believe this is so because when he is scolded, he looks ashamed. What the toddler understands is not that he has hurt someone or destroyed something but that he has earned the disapproval of his parents. Conversely, when praised for being gentle with another, he knows and is pleased that he is approved of for that behavior at that moment. It will take time and many reminders before he can understand that not hitting or biting applies to many situations. Young children, particularly those under three-and-a-half or so, scarcely know their own strength. The differences between a kiss and a bite, between patting and hitting, between nudging and pushing someone down are not automatically understood and children need many reminders: e.g., "Let me show you how to pat the baby (or the family dog or Daddy's cheek)"; "Patting feels nice. Hitting can hurt"; or "Do it softly (or gently), like this."

As is true of the young child's development in other areas, there are steps and phases in the socialization of aggression, and it is worth your while to learn something about what kind of behavior to expect at various ages. If you understand what an infant or toddler or a four-year-old is capable of, you can adjust your own actions and teaching to realistic expectations and save yourself worry and frustration. You don't need the anxiety of imagining that your toddler who gets very angry and has very little control over his aggression when frustrated or upset is destined to become an angry, destructive, uncontrolled four- or ten- or twenty-year-old. On the other hand, if your four-year-old has frequent aggressive outbursts and seems not to be concerned about the effect of his aggression, or even seems to enjoy hurting others, you are correct in being worried and in seeking ways to help him toward healthier behavior.

How then do parents moderate and channel their child's aggression without stamping it out by being too severe? While there is no exact recipe, here are twelve suggestions that may help you to provide your child with the guidance he needs.

1. **Keep in mind that your child's feeling loved and affectionately cared for builds the foundation for his acceptance of the guidance you will provide as his development proceeds.** This includes the regulation of aggressive behavior. Children who feel loved want to please their parents most of the time and will respond to their guidance. Putting reasonable restrictions on your child's behavior is part of loving him, just as are feeding, comforting, playing, and responding to his wishes.

2. **Try to figure out what triggered your child's aggressive behavior.** Ask yourself what might have happened that set him off—your behavior or that of another person, or something else in the situation. Perhaps he is overtired or not feeling well physically. Being rushed, abruptly handled, being denied something he wants, even being unable to do something he has tried to do with a toy or physical activity often produces feelings of frustration and anger that result in aggressive behavior: the toy gets thrown, or the child cries and strikes out or stormily says, "Mommy, I hate you." This can also occur at times when there is no readily apparent cause for the outburst.

3. **Make use of what you know about your child's temperament, rhythms, preferences, and sensitivities.** For example, if you know that he is irritable or ill-humored for the first hour of the day or gets very out of sorts when tired or hungry, you won't pick that time to ask a great deal in the way of control. If you know that he is likely to behave aggressively when another child comes close, you will want to be nearby to help him control that behavior. If he easily becomes "wound up" with excitement and is more aggressive at such times, you will want to help him tone down the excitement so that he can continue to play. If you know that he gets upset, angry, and aggressive when teased, you will want to give him some

protection from teasing by others, especially by adults.

4. Tell your child what you want him to do or not do in a specific situation but try not to give a long lecture. Your child will be aware of you displeasure from your tone of voice as well as from what you say. It is important that you try to be clear about your disapproval. However, long lectures and dire predictions are usually counterproductive. Telling a three-year-old child that God won't love her if she hits her baby brother may frighten her, but it is unlikely to help her understand and develop her own controls. A better reason is that you don't want her to hit him because it hurts. That you don't like the *behavior* is your most effective message. It helps any young child who has earned the disapproval of a parent to be reminded that she is loved even when you don't like the *behavior*. And sometimes the young attacker needs as much comfort as the victim because of the negative feelings that are aroused by one's own aggressive behavior.

5. When your young child is playing with other children, keep an eye on the situation but try not to hover. What begins as playful scuffling or run and chase or sharing toys can quickly move into a battle between children, and they may need a referee. However, there are times when you can let young children work things out among themselves. When you believe that none of the children is in danger of being hurt, you may decide to see how they can settle their differences because if successful, they should be better able to manage the next situation more adequately. Age makes a difference, of course. Such solutions are often within the abilities of three- to five-year-olds, while the under-threes will need your help and protection more frequently.

6. When your child is being aggressive in ways you don't like, stop the behavior and give him something else to do. You may either suggest and help start a new activity or perhaps guide him to a place where he can discharge aggressive feelings without doing harm to himself, to anyone else, to toys, or to the family pet. For example, a corner in which there is something to punch or bang or throw at can be utilized. You can say, for example, "If you feel like hitting, go and hit your pillow (or punching bag), but you can't hit the dog (or bang the table with a hammer)." Such an opportunity not only helps the child discharge some aggressive feelings but also helps him understand that there can be a time and place provided for such actions.

7. When time permits, demonstrate how to handle a situation in which there is conflict between children. For instance, if your child is old enough, you can teach him a few words to use in order to avoid or settle a conflict. A two-year-old can be helped to hold on to a toy and say "no" or "mine" instead of always pushing or crying when another child tries to take a toy. A four-year-old can be shown how to deflect a younger brother or sister who is about to move in on his treasures. Children need specific suggestions and demonstrations from adults in order to learn that there are effective ways to handle disagreements that are more acceptable than physical attack and retaliation.

8. If your child has language skills, help him explain what he is angry about. If you are able to guess and he cannot say, do it for him, e.g., "I guess you're mad because you can't go to play with Johnny. I know how you feel, but it's too late to go today" (or whatever the reason is). Among the things children begin to learn during the early years are some of the connections between feelings, thoughts, and behavior. This learning is accomplished gradually as the child hears what is said about himself and others, and as he is helped to understand that feelings and ideas lead to actions, some of which are approved and some not.

9. Ask yourself if you are sending "mixed messages" to your child about his aggressiveness. If you say "Don't hit" or "Be nice"

while you are not so secretly enjoying your child's aggressive behavior toward someone else, he will be confused, and such confusions tend to make it more difficult to develop self-control.

10. Keep in mind that parents are the most important models for behavior and the creators of the family atmosphere and guidance that children need in order to use aggression in a healthy way. If social exchanges in your family include much arguing or physical fighting in the presence or hearing of your children, you can count on their picking it up. You can expect that they will imitate that behavior in their interaction with others, becoming either excessively quarrelsome or physically aggressive or becoming excessively submissive out of fear.

11. Think about the very real disadvantages of physical punishment for your child. Children often arouse anger in adults when they provoke, tease, behave stubbornly, or attack others. If your practice is to hit or physically punish your child in some other way for such behavior, you need to think very carefully about what he learns from that. Even with the best of intentions, you may be sending the wrong message. Rather than learning how to control his aggression as you want him to do, he may interpret your behavior to mean that physical force always wins out, and he may not develop other ways of settling disputes. There is the danger that he will become even more aggressive or may fail to develop the ability to cope with the ordinary pressures of social contact.

12. Your child's learning to love and live in reasonable harmony with others comes about only gradually and over many years. For you as parents there will always be ups and downs, periods when you despair of "civilizing" your child or when you will worry that he will be too timid for the rigors of the world. While living from day to day with the pleasures and frustrations of being a parent, it is also important to keep the long view in mind: there is a positive momentum to development. This forward thrust of your child's growth and development actually works in favor of his acquiring the ability to channel and productively use those aggressive energies that are a vital part of our makeup.

2

Parenting an Infant with a Birth Defect: The Regulation of Self-Esteem

Dorian Mintzer, Ph.D., Heidelise Als, Ph.D., Edward Z. Tronick, Ph.D., and T. Berry Brazelton, M.D.

While the experience of giving birth to an infant with a defect is similar to other painful experiences, such a substantial trauma confronts new parents with unique intrapsychic and reality based challenges as well. To observe the unfolding of parents' adaptation to the birth of a child with a defect; to gain a better understanding of how these parents handle their own feelings, especially their self-esteem, and develop pleasure in their infant; and to learn about the specific kinds of help needed by these families, we followed five families of infants born with defects over a period of two years, seeing them in home visits and laboratory sessions.

We learned that their reactions were influenced by a complex interplay of factors:

- the severity and correctability of the defect, how they were told about it, and the nature of the medical procedures required;
- previous expectations for the child and their view of themselves as parents;
- their prior means of coping with stress;
- the nature of the marital relationship and their own experiences in the parent-child relationship;
- the infant's temperament and capacity to interact and be organized;
- the uncertainty about the short- and long-range implications of the defect and its impact on the child and the family;
- and the role of environmental supports.

The parents experienced a series of assaults to their sense of self that affected self-esteem and interfered with the parenting process. We observed parents go through three stages of reactions and adaptations to the birth defects: (1) initial sense of shock and disappointment reflecting an intensely felt injury to their sense of self-worth; (2) a period of intrapsychic disequilibrium manifested in loss of self-esteem, painful feelings, inadequacy of defenses, and, at times, inappropriate handling of the infant; and (3) restoration of the intrapsychic equilibrium manifested in renewed parental self esteem, awareness of existing painful feelings but with adequate defenses, and more appropriate meeting of the infants' and of their own needs. During the period of disequilibrium, we found, the parents' capacity to parent is compromised if they view their infant as a negative part of their selves rather than as a separate person. The adaptive tasks for these parents are to identify positive aspects of the infant and to view the infant as a separate individual, rather than as a representation of their own inadequacies; to grieve the loss of their aspirations and ideals for a child and the wished-for relationship; and then, as they begin to reestablish self-esteem, to understand the special as well as the normal developmental needs of the infant and to find ways to experience pleasure in being

a parent given the reality of continuing pain.

Descriptions of the experiences of two of the five families illustrate the stages of reaction and adaptation.

The B Family

Bonnie was a pretty, cuddly infant—active and excitable, yet robust. When excited or upset she could calm herself with a pacifier or become calm in her father's arms. Born with congenital cataracts in each eye, Bonnie did not focus visually nor make eye contact with her parents, who had no way of knowing what kind of sight she would have.

The B's appeared to be nice, conventionally dressed people who looked a little older than their years. Mrs. B had worked until a week before Bonnie's birth, when she took a leave of absence, assuming she would not return to work during Bonnie's first few years. After seven years of marriage, conception had been wanted and planned. Mrs. B wanted a daughter and Mr. B preferred a son. Although Mrs. B had looked forward to natural childbirth, Bonnie was born by Caesarean section after a long, difficult labor.

The parents initially thought they had a healthy infant, but then learned on her second day that Bonnie had severe cataracts. They felt shocked, angry, helpless, and hopeless—"shot down." Magical thinking, confusion, disbelief, and self-blame were in evidence. Mrs. B, for example, immediately envisioned Bonnie as a blind baby but was afraid to ask the doctor questions lest verbalizing her fears would make them come true. Both parents blamed their own poor vision for Bonnie's condition and wondered if Mrs. B had done anything during the pregnancy to cause the problem.

The pediatrician told the B's that Bonnie would need some special attention. Mrs. B wanted to care for Bonnie right away, thinking that since her baby could not see, she would know people by their touch. This wish to provide mothering and to attach was thwarted because of a postpartum infection that separated her from Bonnie for seven days. Her disequilibrium was reflected in her belief that Bonnie immediately developed a preference for Mr. B and would not like her. When she was finally allowed to touch Bonnie, she was afraid to hold her or feed her. She perceived herself as defective and was afraid that she would interact inappropriately with her infant. She regarded Bonnie's crying as an affirmation of her own inadequacy as a mother rather than as a reflection of Bonnie's sensitive state organization.

When the B's consulted two eye doctors and received conflicting recommendations about the timing and number of surgical procedures that Bonnie required, they turned with confusion to their pediatrician for help in the decision. Bonnie underwent a surgical procedure on her right eye when she was 2½ months old. Both parents became increasingly anxious as the operation date approached and decided to delay the surgery for a week so that she could be baptized beforehand. After the first surgery on her right eye, the parents were immediately told she would probably have vision in that eye. Two weeks later, however, the cornea clouded over; the parents learned that she would need additional surgery on the same eye. The second procedure, six weeks later, was followed by three weeks with an eye patch. The B's then learned that this eye had not developed properly prior to birth and that Bonnie had no vision in that eye.

The parents' hopes and fears kept vacillating. Although the surgeon expressed optimism about Bonnie's larger left eye, Mr. and Mrs. B felt betrayed by the surgeon and began to lose trust in him. They wondered if he was leading them on with "false hopes."

Their anxieties and fears persisted on and off until the surgery on her left eye. In short, during Bonnie's first eight months her parents did not know if they would have a visually impaired or a totally blind child.

Mrs. B was depressed throughout this period. She chose to resume her job. This step apparently helped her to regain a sense of competence and self-esteem, she needed

literally to separate from her infant in order to prove that she herself was not defective. Mrs. B was at first unable to acknowledge her painful and angry feelings and maintained a brittle, defensive structure of denial and avoidance. As her professional competence and ability to arrange for the baby's daily care in her absence helped her regain her self-esteem, she found some pleasurable ways to interact directly with her infant. For example, she played a game of touching and tickling with Bonnie which had both mother and child smiling and laughing; thus she achieved her wish for a smiling little girl. Arranging her work schedule to be flexibly available to take Bonnie to the doctor when needed further helped Mrs. B to feel like a good mother. Mrs. B was overly concerned about her own and her infant's appearance during the period of disequilibrium. She always dressed Bonnie in pretty, delicate outfits, taking pride when people commented on Bonnie's cuteness. Despite her visual disability, Bonnie progressed developmentally in other areas.

When Mrs. B was emotionally unavailable during Bonnie's early months, Mr. B assumed the primary caretaking role even though he was extremely depressed and had not planned to provide caretaking for Bonnie since he viewed early parenting as the "mother's role." Mrs. B at times doubted her own competence and at times felt competitive with Mr. B, convincing herself that Bonnie preferred Mr. B since he had provided the early feedings. While Mr. B welcomed and supported his wife's increasing attempts to become Bonnie's caretaker, he also subtly undermined her, asserting that he was more sensitive to Bonnie than she was. Yet as her own internal equilibrium was restored, Mrs. B's feelings of competence as a parent grew. The parenting roles gradually shifted; Mrs. B provided more of Bonnie's care, although the couple continued to share some parenting tasks.

When Bonnie was 8 months old, just prior to her third surgical procedure, and before they learned that Bonnie would have vision in one eye, Mrs. B began to feel that Bonnie needed her and that she was capable of being Bonnie's mother even if Bonnie were a blind child. Mrs. B decided that regardless of the outcome of the surgery, she would take a leave of absence from work so that she and Bonnie could "get to know each other."

After the cataract on the left eye was removed, the parents were relieved to learn that Bonnie would have some vision in that eye. They wished for dramatic changes in her eyesight after the operation and were disappointed that this did not happen, but reminded themselves that Bonnie's use of vision would develop gradually. Mrs. B took three months off from work to spend time with her daughter during the transition from sightlessness to vision.

By age two years Bonnie's motor, verbal, and social skills were well developed, and she clearly knew that she could influence events. She was well-modulated, organized, and calm. She connected words with wishes and could use sentences. She evidenced object constancy, had a good memory, and distinguished circumstances and events in her environment. When Bonnie is older she will undergo surgery to remove the cloudy covering on her right eye so it will look less abnormal.

The C Family

Charles was born 4 weeks prematurely, with 3 fingers on each hand fused, borderline small for gestational age, and suffering respiratory distress. He appeared to be a very temperamental, labile baby: his movements were jerky; he was wide-eyed, easily overstimulated, and disorganized, similar to many small-for-date full-term infants (Als et al., 1976). He needed continuous help with state modulation and organization. He had four operations to separate his fingers between 14 and 21 months.

Mrs. C, a slim, attractive woman who took pride in her appearance, had planned to work throughout her pregnancy, to take a two-month leave of absence after the baby's birth, and then to return to work. Both Mr. and

Mrs. C showed a mixture of easy verbalizations and some denial. While they could talk about previous losses, they could not make connections to current experiences.

Conception was planned and was wanted by Mrs. C, but Mr. C was ambivalent. Each preferred a daughter. Mrs. C had looked forward to natural childbirth and breast-feeding, but was hospitalized in her sixth month because of toxemia. For this reason, she not only missed the prebirth parents' sessions but did not have the entire pregnancy to prepare psychologically for the baby.

After Charles' birth, Mrs. C experienced a narcissistic disequilibrium characterized by feelings of guilt, worthlessness, helplessness, hopelessness, and self-blame. She was emotionally labile, either bursting into tears or laughing anxiously. Mr. C said he was more upset about Charles's prematurity than about the hand defect. Although he reported some sadness about the defect, he either denied or minimized concern by stressing that it could be surgically repaired. His sense of shame, however, was evidenced in his wish to put gloves on Charles's hands so his fused fingers would not be noticed.

The complications of pregnancy, the premature birth, and her infant's minor birth defect had made Mrs. C feel like a failure. Her low self-esteem and anxiety interfered with her early attachment to Charles: she decided not to breast-feed. She was gentle, empathetic, and patient with him, but her negative comments about herself revealed that she did not recognize her own competence. She was not confident that she knew what Charles wanted or how to help him and blamed herself for his behaviors and responses. For example, commenting that Charles had trouble with his bowel movements, she said, "It must be my problem. I keep wanting him to do more." She also said, "He smiles before he opens his eyes and sees what a mess I am," and, "When he's alert and smiles, it's as if he's apologizing."

Gradually Mrs. C found ways to interact with Charles and to enjoy him during the brief periods when he was awake and alert. Eventually she was able to help him to extend the awake and alert periods and to reciprocate in his play. Charles worked hard—and successfully—to engage his mother with smiling, tongue motions, a wide range of vocalizations, eye contact, and cycling of his feet and hands. Charles' ability to tolerate more direct touching and bouncing from his father and his broad smiles brought pleasure to Mr. C and fostered his attachment to his son.

Mrs. C took pride in her own and in her infant's appearance and did not regress to withdrawal or avoidance as much as Mrs. B. She was able to acknowledge and tolerate her sense of failure and disappointment and to ask for help. While this capacity may reflect her somewhat higher level of intactness, it may also have been influenced by her infant's comparatively minor defect, which did not interfere with pleasurable feeding or with face-to-face or eye-to-eye contact and which required no surgery during the first year. After the initial shock and upset, the disequilibrium of the first three months seemed related primarily to Charles's prematurity and subsequent neurological immaturity, which caused his highly sensitive state organization and temperament, and only secondarily to his birth defect.

During his fourth month, by which time Charles had compensated fairly well for his prematurity, the parents began to focus on his fused fingers. Their sense of injury and disappointment were retriggered at this time. Like the B's, the C's received conflicting recommendations regarding the timing and number of surgical procedures. They felt confused and worried about making the right decision. Mr. C said, "The birth defect was predetermined, it happened, we had to adjust. Now it's up to us to decide what kind of procedure Charles should undergo." Charles was hospitalized only during the first procedure to separate his fingers. His

parents took turns being with him in the hospital. At the parents' request the other surgical procedures were done on an outpatient basis. They felt the additional hospitalizations would be too disruptive for Charles and preferred to provide his care at home. After each surgical intervention Charles had his hands bandaged during the healing process.

At age two, although his fingers looked abnormal, Charles had full use of his hands. He was a very active, alert, and engaging child who was functioning within normal developmental limits despite some delay in his speech. Because of his sensitive temperament, he needed a good deal of organizing and structure from his environment.

Parenting a child with a defect

The tasks of parenting a child with a defect are similar to those of parenting a normal child, requiring empathy, learning the infant's cues, organizing and expanding alert periods, and supporting the infant in the gradual development of a tolerance for frustration. While a normal infant is an active elicitor of parenting, the infant with an anomaly may be a weak parental ally in the adaptational process. The lack or distortion of the presence of normal elicitors of maternal responses, such as the lack of smiling, feeding problems, or the lack of eye-to-eye contact, creates a situation in which the initial mother-infant attachment is at risk.

Unfortunately, during the period of disequilibrium, the parents are not yet good allies to their infants. These parents, for example, experienced a real set of insults which included Caesarean section, premature birth, separation from the newborn and specific difficult caretaking needs. Their own lowered self-esteem also interacted with the severity and visibility of the defect to impair their good feelings about themselves and their child. The mothers who experienced the most severe sense of injury and the longest period of disequilibrium suffered many disappointments in their prebirth expectations as to the sex of the infant, mode of delivery, and manner of desired feeding. These experiences lowered their self-esteem and might have put them at risk for parenting problems even if they had had a normal infant. Sadly, they gave birth to infants with continuously visible facial defects which made the initial communication between mothers and child difficult.

The marital relationship

Contrary to the notion that marriages break up with the birth of a child with a defect, we found that a form of balancing reciprocity for coping developed between the adult partners in four of the five families. The birth and parenting of an infant with a defect brought most of these couples closer together over time, although periods of marital disorganization occurred when they were at different stages of the adaptational process. The marital relationship of the Bs in particular underwent a great deal of stress. Both parents experienced their infant as a negative extension of themselves, they had stereotyped notions about parenting, and they lacked the ego strengths of flexibility and adaptability. Both Mr. and Mrs. B, however, believed that they eventually emerged from the disequilibrium functioning better as a couple than they had previously.

Restoration of parental self-esteem

The turning point in the restoration process of parental self-esteem came when the parents experienced their infants as separate persons rather than as negative extensions of the self and found aspects of the infant which they could identify as personal and individual. The parents' experiences with the infant gradually helped to focus their attention on such positive qualities as compelling eyes, cuddliness, and suck, and enabled them to enjoy their child and to enjoy being their child's parent.

As a positive parent-infant attachment developed during this process, the parents began to recognize their infant's cues and

were able to protect the infant, adjusting care and handling to their specific baby as do parents of babies without birth defects. Each infant in this study, similar to infants without defects, found ways to engage each parent successfully within the first months; these responses differed from how they interacted with strangers.

Ongoing sadness continued, but by the end of the study parents were sad for the child's realistic problems rather than feeling primarily self-pity.

Ongoing adaptation

Of course, adaptation was not a smooth process. Throughout the two-year study each family remained concerned about the outcome of surgical procedures, future consequences of the defects, and how the parents would be able to help their child understand and adjust to the defect. When the infants failed to progress according to normal developmental rates or to attain a milestone and when medical procedures were necessary, anxiety, depression, and self-blame were retriggered in the parents. Once the initial intrapsychic balance had been restored, these parents handled these anxieties with increasing adequacy and less regression; they were able to identify the patterns of their reactions and to reconstruct their previous handling of the crisis. This process allowed them to acknowledge openly their current pain and anxiety and simultaneously to recognize their developing coping strategies and energies.

Some clinical signs of restoration of equilibrium included:

- mutual parent-infant interaction patterns as described above;
- integration of the infant into the family so that each member's needs were met—the mothers were able to relinquish the care of the infants to others, freeing time for the spouse or for themselves;
- an end to devaluing the parent and infant—the mothers started taking better care of themselves physically, participated in activities such as travel or socializing without the children, took the infant to visit relatives, or invited grandparents or friends to come and meet the infant;
- activities to regulate self-esteem—the mothers would resume their job or start an activity to enhance prestige;
- development of a clear picture of the infant as a separate individual—all five sets of parents could describe their infants' strengths and difficulties with increasing specificity, identifying the defect directly and discussing its implications for their children.

Clinical implications

Although its purpose was not therapeutic intervention, we found that our developmental research approach in fact provided a model for clinical help to parents of infants with birth defects. This model focused on the parent-infant relationship and served to enhance parents' self-esteem and to foster their affection for and mutuality with their infants.

Overall, the research team developed a sequence of interventions. First, we focused on helping each parent gain specific knowledge about his child's behavioral organization and style. Second, parent-infant interactions were discussed, the team often pointing out how the infant needed and responded to the mother and had learned to differentiate between the parents. This helped to diminish parental competition since the parents saw how they complemented rather than duplicated each other, thus providing richer opportunities for the infant. Third, as the observational process continued, the team at times intervened in the parent-infant interactions or addressed specific issues of the parents, such as their sense of injury, need for grieving, options for themselves, or their marital relationship. At other times, child rearing issues such as limit setting, bedtime procedures, and responses to tantrums were discussed. When appropriate, we observed some periods of parent-infant disorganization without intervening, so that the parents

could find their own ways to develop mastery.

An awareness of the family system was necessary to determine the kind of intervention that would be helpful; that is, to assess whether parents might benefit from affective help, such as identifying and acknowledging feelings, having a cognitive framework within which to understand reactions and adaptations, and/or educative help about child development and parent-child interactions. In this sample parental adaptation included the parents' normal and reality-based sadness for the child and awareness of their own ambivalence. How the adaptational and parenting processes would have progressed for these families if the team had not been involved is impossible to answer. The research team clearly helped to prevent additional crises and helped to maximize parental attachment to the infants.

Our findings certainly suggest that the parents of firstborn infants with congenital anomalies need empathy and help specific both to their problems and to their own level of ego intactness. Because issues of parental adequacy and restoration of parental self-esteem continue over time, clinical support needs to be ongoing and include all aspects of the child and the family.

Parent-centered and parent-infant-centered intervention should occur as early in the newborn's life as possible so that patterns of distortion do not solidify but are transitions to new levels of functioning which yield a strong, positive affective relationship between parent and child.

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3

The Immediate Impact of the Birth of a Low Birth Weight Infant on the Family

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"He was on display in a brightly lighted glass case and it seemed indecent to look." The words are those of Peggy Stinson, the mother of a boy born 16 weeks early and weighing one pound, 12 ounces. These words reflect the power of the feelings evoked by the birth of a premature infant. The early end to the process of gestation not only results in the interruption of fetal growth and development, but also interrupts the psychological process through which the pregnant woman and her husband evolve with their fetus in preparation for beginning their relationship to their newborn.

In order to understand the impact of the birth of a premature infant on his family we must start with an appreciation of the psychology of pregnancy and birth.

In the first weeks and months of pregnancy, a woman may deny the full implications of being pregnant. Actual changes in her physical being are minimal and there may be no change at all in her lifestyle. But almost all women are aware that they are pregnant on a physical as well as an emotional level. The physical symptoms of nausea, gastrointestinal discomfort, changes in breast and silhouette may be exaggerated by some women who are in conflict about their pregnancies. In any case, this is a time of great need. A pregnant woman requires the reassurance of her partner, the support of her friends and relatives and medical support to emphasize normalcy of herself and her pregnancy. At this stage of pregnancy women do not focus so much on "having a child," but, are more concerned about "being pregnant."

As the pregnancy continues into the fourth and fifth months, the reality of the fetus and its relationship to the mother becomes primary. The physical changes in the woman's body, combined with the movement of the fetus in utero, are a constant reminder of the pregnancy. With the growth of her abdomen the pregnant woman begins to relate more directly to her fetus. She begins to imagine which sex the child might be, may give it a nickname, and begins to fantasize about the child's role in the family. Women frequently regress and feel more in touch with experiences from their own childhood during this time. They begin to anticipate the reality of being a mother and verbalize the desire either to be like their own mother or to be quite different. These middle months of pregnancy are often associated with a decrease in the incidence of nausea, gastrointestinal discomfort and fatigue, and free the mother to have a more positive attitude about the pregnancy and the impending delivery. A euphoric sense often occurs which may mask some of the common fears and concerns of the pregnant women. The entire family begins to give increasing attention to the fetus, and a process of maternal-paternal-fetal relationship develops.

If the pregnancy continues to term, anticipation and excitement increase and the reality of having a child and preparing for

it becomes paramount in the lives of the couple. A premature birth, then, abruptly interrupts this nine-month developmental process. It does not allow for appropriate closure on the developing relationship between mother, father and fetus which will be nurtured into the relationship to the normal-term newborn.

We should also be aware that all pregnancies are associated with some ambivalent feelings, and that in some instances, during the time of previability and up to even 20 to 24 weeks, mothers and fathers frequently think about, but rarely discuss, the idea of an abortion. Thus, a baby born between 24 and 30 weeks, extremely premature, may dramatically highlight the ambivalent feelings concerning the potential for abortion which was a legal and possible alternative just a few weeks prior to the actual delivery.

The feelings toward the end of a normal pregnancy are so intense that the actual birth of the baby may be for some mothers an anticlimax. Just as the anticipation of a gift is often greater than the reality, the birth of the child can be a letdown. Disappointment, fear, anger and depression are sometimes associated with the delivery of a full-term baby. This possibility is dramatically increased in the birth of an abnormal or low birthweight infant. All mothers and fathers face some fears of inadequacy in regard to caring for a new human being. They face concerns about financial matters and worry about the impact of this new person on the family, the potential intrusion on their intimacy and closeness, and other changes in the relationship between the parents and other members of the family.

The birth of a normal child helps reaffirm the parents' belief in their own normalcy and culminates in the excitement of confirming their ability to create a person in their own image. There is great relief that the baby is "normal," and a need for their observation to be confirmed.

When a child is born prematurely, little of this can occur. The parents are devastated. As all newborn infants are in some sense felt by their parents to be extensions of themselves, the extremely small, fragile and vulnerable premature infant may readily evoke feelings of self-deprecation and lowered self-esteem. Fears occurring during the pregnancy that the baby would be abnormal are powerfully reactivated. The joy most often associated with an infant's birth is diminished and the parents feel a sense of fear, failure, guilt, anger and depression.

Parents have intense feelings immediately after the birth of a low birthweight infant. Most parents experience immediate grief reactions that are similar to those occurring at the death of a loved one. The parents may mourn the loss of the expected perfect child and begin to go through the process of anger, denial and depression. The mother particularly has an acute sense of failure. She, as the person in whom this infant was to have been carried to term, has failed in her task. Denial and guilt characterize the response and serve as defenses to ward off the more devastating feelings of anxiety and depression.

Having to deal with uncertain outcome is the single most anxiety-producing aspect facing the parents. The question all parents of low birthweight infants ask is: "Will he live or will he die; and which is the better alternative?" Understandable thoughts that the child might be better off dead are frequently felt to be unacceptable. Parents try to push them out of their minds but they continue to intrude. During this time of crisis parents may regress and themselves behave like emotionally labile children. They will certainly require a great deal of nurturing, comforting and sensitivity to their own personal needs.

The ambiguity of outcome, the fear of what the baby's living will mean and the equal fear of the baby's death frequently result in terrible feelings of helplessness and loss of control. In addition, parents have little sense that this baby really is theirs, so completely has its care been handed over to physicians, nurses, technicians and

machines. The medical jargon becomes second nature as the parents are co-opted into using terms like: blood gases, pO2, apnea, IVH, NEC, bradycardia, etc., etc. They must adapt to these terms, adopt a new vocabulary and become part of the medical establishment in order to feel any part of the process of caring for their infant.

The father plays a unique role in this process. Frequently, mother and baby are simultaneously hospitalized but in two far-distant sites. They may be far distant in the same building or in two different buildings, sometimes many miles apart. The father is often responsible for reporting the status of the infant to the mother. Because of their tendency to be protective of mothers who are often depressed and anxious, fathers frequently share only part of the information about the babies. However, this attempt to protect often isolates the mother and intensifies her feelings of lack of control and involvement, and increases anger, guilt and loss. The father is often focused on the monumental costs of the care and the future costs of rehabilitation, special schooling and changes in the home environment which this infant will occasion. The father's loss of self-esteem may also focus on his fantasies about playing baseball and football or taking his child to a sporting event: the birth of this sickly and puny child may smash such images. Whatever the reassurances about future potential, the father may focus on the weakness rather than the strengths of his infant.

No matter what the outcome of the low birthweight infant, parents must accomplish several psychological tasks during the hospitalization of the low birthweight infant if they are to bond and adapt in a meaningful way to their newborn. The period of shock and denial, sadness, grief, anger and anxiety must make way for a period of adaptation in which the family begins to relate in a meaningful way to the infant, even while he is sick; and, finally, the family must reorganize, coming to grips with the infant's special needs and prepare for the infant's discharge to the home. These stages are not unlike the stages of resolution of the grief work during the mourning for a loved one who has died. The adaptation and reorganization phases allow the family to view the infant's potential and future more realistically and with a more positive attitude.

What of other family members? What about grandparents, aunts and other close relatives and the other children? Adult relatives frequently go through the same stages that the parents of the infant are going through. In their initial stage of anger, denial and disbelief, relatives may blame the parents for what has occurred. They criticize the mother's lack of ability to carry the infant to term, and often focus on either social activities or behaviors that the mother or father engaged in which they believe are responsible for the early birth. Grandparents frequently deny the seriousness of the illness and in an attempt to be reassuring, they, too, may bring inappropriate information back to the mother. What about the other siblings? Not having been prepared for the birth of a premature infant, siblings at first may react with considerable fear to the loss of their mother when she is hospitalized unexpectedly. This is followed by possible misunderstandings about why the baby can't come home and what the potential problems are concerning the baby's illness. Parents in their misguided desires to protect the siblings will often hide the fact that the infant is sick and try to keep their own personal grief from their children. This, of course, is a hopeless endeavor; their children immediately pick up the anxiety, tension, depression and sadness which the parents inadvertently manifest in their every moment together.

What then do we suggest the professionals in the neonatal intensive care environment can do to assist in minimizing the negative impact of the birth of a low birthweight infant on the family? How can they help the parents to progress through the necessary psychological stages of coping with their new infant? The first and most

important issue is the attitude of the professionals. Although the nurses, physicians and even social workers caring for hundreds of infants per year in a special care nursery take for granted much of the illness they see, it must be realized that for each and every parent any deviation from the norm is viewed as a serious and even catastrophic event. Although a premature infant may be doing well on a ventilator in the nursery and be viewed as a "healthy," rather "usual" case, the birth of a very low birthweight infant is clearly not a usual event for the family and must not be treated as such by the staff in the neonatal unit. Professionals must realize that although the patient is "routine" to them, the baby is unique to the parents. Jargon is frequently overused in discussing the baby and may unnecessarily distance the staff from their patients' families. It is important to clarify each aspect of the care and the prognosis in simple lay language and to be sure that the parents are allowed to question all of the terms that are used in explanation. Frequently, during the first visits of parents to the unit the monitoring equipment and all of the tubes and wires connected to the infant are misunderstood as not merely recording the activities and biochemical variables of the infant, but rather affecting the infant; thus, the monitoring leads attached to the chest or the temperature probe attached at the abdomen are viewed as routine within the nursery structure, but to the uninitiated parent they appear as major invasions of their infant, perhaps giving electric shocks, or worse. With time, reassurance and patience, the parents can be made to feel comfortable in the unit and helped to understand their baby's illness.

Much has been written about the importance of regional neonatal transport, moving a neonate from a community hospital to a far-distant neonatal center in order to enhance newborn outcome. It is vital to be aware of the psychosocial aspects of this intervention. The attitude of the team, the eagerness to discuss the infant with the family while at the referring hospital, and the literal way in which they handle the infant are all critically important. A polaroid picture of the infant becomes the treasured link between mother and baby for many hours or days and is frequently caressed, kissed and talked to. The mother must see her infant prior to the infant leaving the hospital, even if the infant must be rolled to the mother's bedside in a recovery room or another part of the hospital; and, finally, the transport of the infant is not completed until a phone call is made to the mother in the hospital of origin to assure her that her infant's trip is over and her baby is in its new environment. This is done whether or not the father has come with the infant and plans to return immediately to the mother to give the same reassurance. This phone call, placed by the nurses or doctor caring for the infant in the center, has been one of the most powerful gestures of concern for mothers of any gestures made in the neonatal unit. Mothers' responses are overwhelmingly positive.

As the parents of the infant begin to visit the neonatal unit, it is important to realize that parents are facing totally new experiences with no background for understanding what would constitute appropriate behavior. The family must be educated sensitively about their "right to visit," their "right to ask questions," and their "right to call." Conferring these "rights" expresses a desire on the part of the neonatal unit staff for parents to have a meaningful role in the care of their newborn. These attitudes permit families to feel that they are still involved with their infant although they have lost control of the moment-to-moment care. The emergent nature of much of the care in neonatal units precludes long "informed consent" discussions about many treatments and procedures, but parents can and must be respected in their right and wish to know what is happening to their infant and to be involved in decision making as much as possible. Giving parents knowledge and understanding about what is

happening with their infant and some involvement in decision making empowers them and enables them to feel they have a meaningful part in the care of their newborn.

Despite the fact that the vast majority of low birthweight infants in the 1980s survive, some infants will die. A humane, caring and compassionate approach to death in the neonatal unit is an important part in helping the family deal with this tragic event. Prolonging an inevitable dying process is inhumane and unnecessary. Families should be involved in touching, holding and comforting their infant as the infant's life ends, just as they were during the baby's life. A quiet place in the nursery should be set aside for parents to spend those last moments playing the role of parent, holding and comforting their dying loved ones. Compassionate and caring physicians and nurses who spend as much time and energy in the process of their patient's dying as they did in their attempt to rescue their patient's life will play a meaningful role in the family's attempts to cope with this event. Comments like "it's for the best," "he's suffered a great deal," "it's good that it's over," are both inappropriate and unnecessary. Spending time with the family, sharing their grief, and understanding their sadness is more helpful and more meaningful. It is also important to reassure the family that staff will be available to talk with them about this experience later. It is important to meet with parents within a few weeks to reflect on what has occurred and to help them adjust to their lives without the baby they had wanted.

Modern neonatology has given us optimistic mortality and morbidity data concerning low birthweight infants. Just a few years ago, a two-pound infant had a 10 percent chance of survival, and those who survived had major neurologic and cognitive deficits. Today, the overwhelming number of two pound infants survive and survive intact, with some developing minor, and fewer developing major, deficits. These data do not change the dramatic impact of the birth of these low birthweight babies on their families. The media have suggested that prematures will survive and most will do well, but when that premature infant is born, the family will need do deal with all of the feelings described. Professional caregivers for the newborn must be available for parents, to help them face this crisis and to deal with the deep emotion involved. The result will be a healthier family and a healthier baby.

4

Infant-Parent Psychotherapy with an Autistic Toddler

Barbara Kalmanson, Ph.D. and Judith H. Pekarsky, Ph.D.

The case presented here describes the treatment of Jonah, an autistic child who came to us as a toddler and whom we followed to the age of five. The work took place through the Infant Parent Program, and Infant Mental Health Program, begun in 1979 by Selma Fraiberg, and modeled after her innovative work at the University of Michigan. The Infant-Parent Program is part of the Department of Psychiatry at the University of California, San Francisco, and is based at San Francisco General Hospital.

The approach to the treatment of Jonah and his parents was an outgrowth of the method of infant-parent psychotherapy described by Fraiberg and her colleagues (Fraiberg, 1980; Pawl and Pekarsky, 1983; Lieberman, 1983). In line with this model, the primary goal of the work was to develop a mutually satisfying relationship between the parents and their child. This involved careful attention to the parents' feelings and a focus by both therapists and parents on the child's affective experience and needs.

Assessment

Jonah's family was referred to the Infant-Parent Program by his pediatrician when Jonah was 18 months old. He had been having staring spells for the last two months and often seemed extremely aloof, preoccupied, and difficult to contact. There were episodes of such inaccessibility that neither his mother's shaking him nor passing her hand in front of his eyes brought any response. In the previous two months Jonah had stopped using all but three or four of the 15 words he had acquired.

In the course of our assessment, it became evident that both of Jonah's parents were in crisis. They were reacting to the difficulties in making a connection with Jonah and felt bewildered, rejected, and helpless. They were continuing to reach out to their son, but with a sense of increased foreboding about their ability to get a response.

As the assessment proceeded, Jonah's developmental history gradually emerged. Jonah was the Burkes' only child, the product of an uncomplicated pregnancy and delivery. From birth, Jonah was extremely irritable and unusually sensitive to light and sound. He had difficulty with state transitions. He cried for long periods and was very difficult to console.

Jonah's major developmental milestones were all within normal limits although no truly social smile had ever developed. Following breast feeding, he insisted on feeding himself and refused any lumpy or rough textured foods. Jonah also showed an intolerance for shifts and changes in his routine or environment.

At the time of the assessment, Jonah's affective and social functioning, his sensory integration, and his cognitive abilities were atypical. He was able to remain solitary and unrelated for long periods of time, never approaching his parents for reassurance, for comforting at times of distress, or to share moments of pleasure. Jonah never allowed mutual eye contact or cuddling, and

squirmed in distress in his mother's lap. His typical method of making contact was to direct the other person's hand like a tool in order to reach an object or facilitate its use. Jonah's slight and fleeting smiles were evoked by his own activities with toys, and the pleasure was experienced privately.

There was evidence throughout the assessment that Jonah had difficulties with sensory modulation and perceptual integration. He seemed easily overwhelmed by sensory input and gave evidence of unusual sensitivity to a variety of visual, auditory, olfactory, and tactile stimuli. When he experienced stimuli as too intense, he was driven to complete withdrawal and preoccupation with self stimulatory activity.

Jonah's cognitive functioning was markedly uneven. He showed serious difficulties in language—with an unusual mixture of infantile vocalizations, squeals and squeaks, and two or three words not used communicatively. Jonah's comprehension of language appeared limited to the recognition of a few key words and invariant phrases paired with a consistent gesture or visual cue. In the area of symbolic functioning, he showed little evidence of early imitative abilities, object permanence was as yet incompletely established, and he had no representational play. In contrast, Jonah demonstrated precocious abilities in visual-motor performance.

The possibility that Jonah's disturbance resulted from a seizure disorder or hearing impairment was investigated and ruled out during the assessment.

When our assessment was completed, it was clear that Jonah met all the criteria for the diagnosis of infantile autism delineated in the American Psychiatric Association's Diagnostic and Statistical Manual III (1980). The onset of his difficulties occurred before 30 months: he showed a pervasive lack of responsiveness to others; he had gross deficits in language; and he was resistant to change. He also showed some of the "associated features" of this diagnosis: he was over-responsive to sensory stimuli, and he demonstrated marked variability in his intellectual functioning with deficits in verbalization and symbolic thought and excellent performance on visual-spatial tasks. Jonah's intellectual strengths identified him as among the better functioning children with this diagnosis and suggested a good long-term prognosis. We therefore viewed him as in a good position to make use of our interventions.

First year of treatment

To meet the needs of all the family members, our usual model (Fraiberg, 1980) of infant parent psychotherapy was modified. Two therapists worked simultaneously in the family's home, meeting once a week for sessions usually lasting an hour and a half. This arrangement allowed one therapist to provide Jonah with the undivided attention he required to become engaged in the social world, while the other therapist was available to respond to Mr. and Mrs. Burke. The actual work with the child and his parents continually intersected and coalesced as Jonah and Mr. and Mrs. Burke attended to and interacted with one another, and the therapists.

Mr. and Mrs. Burke

The treatment in this case included the most devoted and sensitive collaborators—Jonah's parents. They were in the prime position to help Jonah develop into a social and communicating being, since they were with their son continuously. The work with the Burkes was aimed at removing any internal barriers to rewarding interaction with Jonah. This involved exploring and offering continuous support around their complicated feelings about Jonah and themselves as parents particularly their sense of unimportance to him, their frustration and anger, and their feelings of responsibility and guilt. Along with the support provided, efforts were made to point out when there were signs in the sessions of Jonah's attachment to his parents, and evidence in his behavior that he was

registering and responding to their feelings. This allowed the Burkes to risk more attempts to contact their son.

Another major issue in our early work involved exploring the ways in which the Burkes' reactive feelings had influenced their relationship with Jonah. They reported that life was so difficult with him, they were nearly ready to give up. Through experience they had learned not to disturb Jonah, and they had become somewhat hesitant and tentative in trying to contact him. As they recognized this dynamic and its consequences, and as they began to glimpse some possibilities for interaction with their son, they became more able to reach out to Jonah and engage him.

Another aspect of the treatment involved investigating and revising the Burkes' many misconceptions about the meaning of Jonah's perplexing behavior. They came to understand that Jonah was not unwilling to relate to them, but was engaged in an internal struggle to manage stimulation. This understanding enabled the parents to empathize with their son and wholeheartedly engage in efforts to help him. The Burkes were eager participants in all of this work, and they rapidly became the skillful extenders of Jonah's treatment. This does not mean that they became therapists; rather they were able to sustain natural parental feelings and functions while providing their son with the special kinds of interaction and structure which he needed.

Jonah

During the first year of treatment our work with Jonah was primarily focused on encouraging reciprocal social relationships and developing mental representation and language. In order to make him available for relationships we also needed to learn how to manage the environment for him by modulating the sensory stimuli that caused him to withdraw.

Throughout the sessions with the family, I[1] attempted to follow Jonah's lead continuously and use every opportunity to gratify his wishes and draw his attention to the rewards of interaction. In my search for ways to engage Jonah and maintain his interest in social interaction, I experimented with various dimensions of environmental stimuli—including vocal inflection, and speed and intensity of voice, integrated with tactile stimulation and an optimal physical distance for maintaining eye contact.

I remained constantly available to Jonah throughout each session. Whenever I had the opportunity, I encouraged him to use me to open a latch, reach an object, or hand him a toy. I always handed him the object in our mutual line of vision so that he had to notice my face and hands simultaneously as I gratified him. He could not overlook the fact that this tool-like hand was part of the person who was responding to his wishes. Often, this entailed lying on the floor next to him, or scurrying about the apartment in tandem.

Over the course of many sessions, we evolved a repertoire for exploring the kitchen cupboards which made Jonah dependent on me for help. He needed me to lift him onto the counter top and to secure his mobility from one counter to the next. This exploration had other advantages as well. It put us precisely at eye-to-eye level, facilitating eye contact. Jonah's pleasure in his access to previously inaccessible territory allowed me to encourage small moves toward exploration without interfering with his familiar ritualized routines. I was also able to interpret to the Burkes that his interest in the kitchen represented an interest in them since they were avid cooks. Over many weeks, Jonah's exploration developed from a perseverative opening and closing of the cupboard doors and opening and closing of spice jars, to an interest in the smell of the spices, and eventually in tasting some unfamiliar foods in the cupboard. Because of his previous aversion to crunchy foods, his mother was quite surprised one day to see him nibbling at raw noodles. Gradually, Jonah began to try these new tastes during meals.

[1]The primary therapist for Jonah was Barbara Kalmanson. The primary therapist for Mr. and Mrs. Burke was Judith Pekarsky.

The curriculum in the cupboards gradually led us to naming objects, pouring beans and popcorn from one size container to another, water play in the sink (which included learning to undress and dress) and finally to the beginnings of representational play—pretend cooking with playdough. Pretend cooking became a favorite pastime for Jonah. His interest in cooking reinforced his parents' gradually developing awareness of their importance to him, and a recognition of his beginning identification with their involvement in cooking. Food preparation became the arena for family activity: the Burkes now included Jonah in all their baking, and even prepared home-made playdough.

Another of the reciprocal activities Jonah and I developed grew out of his parents' concern about some ritualistic behaviors that irritated and exhausted them. The most frustrating of these was an opening and closing of doors which rapidly disintegrated into frenzied banging. This seemed to be a rough experimental attempt to find out where things were when behind a barrier. Once we discovered this explanation for the behavior and discussed with Jonah's parents his attempts to develop object permanence, we were able to transform this ritual. We turned it into a social game that would satisfy Jonah's quest for object permanence, promote his use of people as help mates in the learning process, and offer relief and an active role to his parents. We substituted a large box that Jonah could disappear into and reappear from.

Within a week, the box had become a focus of social activity between Jonah and Mr. Burke. Jonah's scurrying in and out of the box included opportunities for mutual gaze, vocal greetings, social smiles, and physical contact. On occasion, Mr. Burke's pleasure in this interaction and his wish for demonstrations of his importance to his son propelled him to follow his own desire for more intimate contact. Jonah's response was to arch his back, pull away, and turn his head from side to side, escaping his father's attempts to embrace. With our support and guidance, Mr. Burke was able to understand that Jonah's avoidant behavior was not a rejection of his father but an effort to protect himself from overwhelming sensory stimulation. Such explanations helped Mr. Burke endure these rebuffs and carry on the game with the intensity of contact Jonah could manage. As a result, Jonah was able and willing to maintain the contact with his father. These shifts interrupted the well established cycle in which Jonah retreated when overstimulated and his parents gave up in despair.

As the reciprocal routines around the box became a comfortable part of daily play, the frenzied quality of Jonah's behavior disappeared: with his parents' warm approval, he had no need to fight their prohibitions with ritualistic insistence. From our point of view, the box set an ideal stage for social play. The game gave Jonah mastery over disappearing objects, and a contingently responsive interaction complete with verbalizations and eye contact. This experience always led us to look for the meaning in Jonah's sometimes apparently senseless behavior, and to attempt to transform his rituals into socially playful interactions that addressed the developmental task he was, however primitively, attempting to master.

After six months of treatment, Jonah had developed an interest in people. He attended to social interaction and showed pleasure in his parents' and the therapists' involvement with him, as long as we mediated the environmental stimuli, were attuned to his interests, and joined his activity.

At this point, we were able to focus more intensely on interpersonal communication. From the beginning, I had drawn his attention to speech by minimizing the number of words directed to him, slowing the pace of speech, and exaggerating inflection and facial expression. I provided an extremely simplified, slow-paced, repetitive monologue describing everything he was doing, as well as everything his parents and I were doing to interest him in relating.

DEVELOPMENTAL SIGNS OF AUTISM IN THE FIRST THREE YEARS OF LIFE

Autism is a pervasive developmental disorder with onset before 30 months. There is increasing agreement that the syndrome is actually present from birth. Typically, however, it is not identified until the child's failure to develop communicative language is apparent. Recent research on infant development and infant-parent interaction provides information that may allow earlier identification of the disorder.

Below are some developmental signs of autism which professionals might keep in mind. It is important to be aware that no single atypical behavior is indicative of autism. The disorder is defined by a pattern of behavior that includes difficulties with social relationships, communication, perceptual integration, and adaptability to changes in the environment.

Signs in Infancy

MOTOR	PERCEPTUAL	SOCIAL-EMOTIONAL	LANGUAGE	MENTAL REPRESENTATION
Inactive • flaccid muscle tone • rarely cries *or* Irritable • inconsolable • only soothed when in constant motion • limp *or* • rigid when held • arches away from close physical contact *May have given up or lost an acquired skill*	Unusually sensitive to sensory stimuli Auditory: • appears deaf to voice but jolts or panics at environmental sounds Tactile: • refuses food with rough texture • adverse reaction to wool fabrics—prefers smooth surfaces Visual: • sensitive to light • may panic at change in illumination • preoccupied with observing own hand and finger movements	Unresponsive • no social smile • avoidance of eye contact when held • fleeting eye contact at a distance • lack of anticipatory response to being picked up • seems not to like being held • seem content left alone • fails visually to follow coming and going of primary caregiver • doesn't play peek-a-boo or patty-cake or wave bye-bye • fails to show normal 8-month stranger anxiety *Fails to form strong personal attachments*	*Delays in or absent use and/or expressive vocalization* *Failure to imitate words, sounds* *Little communicative use of gesture* *Speech retarded or shows processing sequence followed by failure to use previously learned words*	*Decreased visual pursuit of objects or people* *Object permanence develops slowly or stops at stage 2 or 3 (secondary circular reactions)*

Signs in Second and Third Years

MOTOR	PERCEPTUAL	SOCIAL-EMOTIONAL	LANGUAGE	MENTAL REPRESENTATION
Toe-walking Rocking Hand-flapping Whirling without dizziness *Perseverative movements*	Withdrawn from environmental stimulation Engages in self-stimulation Preoccupied with spinning objects Suddenly aware of activity and shows rote space, often with hyperextension of neck	Mimics adult's hand like a tool Insists on sameness and ritualistic routines	Echolalia Delayed echolalia unrelated to social context Pronoun reversals Very literal, holistic, scriptlike	No representational play Little appropriate use of toys Preoccupied with impersonal nonsocial information (e.g. television commercials)

Following continuous observation and discussion during our sessions, the Burkes began adopting all of these approaches to interaction, adapting them to their own interpersonal style. Jonah began imitating sounds, single words, and phrases from bits of conversation as his eye contact improved and as he was encouraged to imitate words that verbalized his wishes.

Jonah's advances in the development of symbolic thought and verbal expression, and his investment in relationships led to a change in the treatment. The focus of the work with him shifted from developing the cognitive and affective components of human relatedness to understanding Jonah's affective experiences.

Second and third years of treatment

Treatment with this family continued for three and one-half years. After the first year, our work with Jonah centered on events in his family and the typical concerns of a preschooler. Jonah did show residual autistic characteristics in language, symbolic thought, and insistence on sameness. These were addressed through subtle interventions embedded in the playful interactions between Ms. Kalmanson and Jonah. The work with the parents during this period supported their empathy and practical efforts on Jonah's behalf. It also extended to their handling of emerging age-appropriate self-assertion and aggression. By the end of treatment, both parents appeared thoroughly pleased with their son and their relationships with him. They enjoyed him, were proud of his achievements and personality, and felt like generally effective and well-loved parents.

At the time of termination, around Jonah's fifth birthday, the only remnants of his former autistic state appeared in some concretization of abstract concepts and less flexibility in his expressive language than is usually available to a bright five year old. These did not prevent him from acceptance at a kindergarten in an excellent private school. Jonah's intellectual abilities were above average, as measured by the Wechsler Preschool and Primary Scales of Intelligence (WPPSI). Socially, he was a very engaging, related little boy, with a fine sense of reciprocity in interactions. He had a full and sophisticated range of affective expression, and readily empathized with the experiences of those around him.

Several months before the treatment ended, Jonah summarized his own understanding of the metamorphosis that had taken place. Recalling a time when he was much younger and unable to make his wants known through language, Jonah wrapped himself up in a blanket and explained that he was in a cocoon. He then depicted his emergence from this state by rising out of the blanket, arms outstretched, with an elated expression on his face. He exclaimed, "Now I'm a butterfly!"

Discussion

The outcome of this case was especially successful. Although some autistic children develop equally sophisticated cognitive abilities, they generally continue to show affective and social peculiarities. It is highly unusual for an autistic child to develop and express a rich and varied emotional life, and to respond to others with empathy as Jonah did. This seemed to be a direct result of the treatment's focus on Jonah's affective experience and needs, and on his parents' ability to empathize with and respond to these.

A set of factors in the family enabled the treatment to proceed so successfully: Jonah's age at the beginning of treatment, his cognitive strengths, and the Burkes' ability to use and extend the treatment. The fact that contact began when Jonah was only 18 months old allowed the work to capitalize on the plasticity of the earliest years. Jonah's age also meant that his cognitive and affective delays and distortions had not yet grown to irremediable proportions. He still had relatively little catching up to do. Jonah's developmental strengths, apparent in earliest contacts, bespoke a constitutional

intactness which enabled him to make good use of intervention.

Finally, Jonah's parents were central to his recovery. Mr. and Mrs. Burke were able to develop and sustain an exceptionally sturdy therapeutic alliance on behalf of their son. They were willing to engage in painful self-exploration and were capable of setting their own needs aside in an effort to provide extraordinary care for Jonah. The Burkes were steadfast in their commitment, patient in the process of improvement, and creative in the extension of the treatment into their daily lives.

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5

Infants and Toddlers in Hospitals: Addressing Developmental Risks

Joy Goldberger, M.S.

Hospitalization represents one brief segment of some children's early experience; it is a repeated event for others, and becomes a way of life for a few. Of the infants and toddlers who are admitted to hospitals daily, some will have diagnoses that suggest full recovery while others will face chronic or progressive medical conditions. The process of providing essential treatment for these very young children may require simple IV therapy, one or many diagnostic procedures, one or many surgical procedures. During their contact with numerous, ever-changing hospital caregivers, many interactions will involve pain or discomfort, most interactions will be somewhat intrusive, and few will be responsive to the child's own cues. Feeding may be prohibited, severely restricted, or encouraged beyond the child's natural desire to eat. Physical restraint may be necessary for varying periods of time. Discomfort with little relief. Parents may or may not be available.

Surprisingly little attention has been paid to the experience of acutely and chronically ill infants in hospitals, other than those in neonatal intensive care, even though it is estimated that more than half of pediatric in-patient beds are filled by children under three years of age (American Academy of Pediatrics, 1986). This article describes the disruptive, chaotic and noncontingent qualities that hospitals share with other high-risk social environments; explores the developmental implications of these circumstances for infants, toddlers and their families; and suggests strategies for care to address the developmental needs of very young children who are hospitalized.

The hospital environment

In examining the social and developmental characteristics that typically accompany even high quality medical care, investigators have described the chaotic and non-supportive nature of the hospital environment (Goldberger, 1987, and in press; Grant 1983; Hagemann, 1981a, and 1981b; Jones, 1979; Smith, 1976; Thompson, 1985).

The physical environment is both monotonous and unpredictable. Sensory experience may be fragmented: tube feedings, for example, bypass the normal experience of sucking, swallowing, tasting and physical contact; the sounds of machinery or continuously playing televisions and radios cannot be connected visually to their sources by young infants (Jones, 1979). Life-sustaining care may involve both pain and unrelenting hunger as a result of restrictions on oral feeding. Infants and toddlers are restrained during medical procedures and to prevent pulling at or exploring medical tubing; they may also be confined in cribs, highchairs and playpens if caregivers are not available to supervise exploratory play.

A large proportion of social interactions in hospitals are non-contingent and intrusive. The large number of frequently changing caregivers may be particularly challenging to very young children. Contin-

ent, responsive care is made less likely by tracheostomies, respirators or the effects of handicapping conditions, which may make language for the young child impossible or difficult to interpret. Particularly for infants and toddlers with chronic conditions who become "favorites" during extended or repeated hospital stays, social interactions are typically highly stimulating, intrusive and sudden, much as are caregiving interventions. With the good intention of eliciting a smile or a cute trick, but often without empathy for the child's emotional or physical experience or developmental needs, numerous loving caregivers may interact briefly and in rapid sequence.

Despite the changes in hospital policy that followed seminal research on the developmental effects of separation and institutional care (Bowlby, 1960; Bowlby, Robertson, and Rosenbluth, 1952; Edelston, 1943; Provence, and Lipton, 1962; Robertson, 1958; Spitz, 1945) prolonged infant-parent separations still occur frequently and are of great concern. How long a separation is too long for a child to tolerate depends on numerous factors. Despite hospital policy that at least formally encourages parents to "live in," lengthy or repeated hospitalizations, parents' work responsibilities, the needs of other children, and lack of adequate transportation may make parents' absence necessary. The quality of interaction between parents and their young child may also suffer during hospitalization. Fear, guilt, grief, depression, exhaustion or inexperience and immaturity may exacerbate parents' emotional unavailability as well as inhibit their physical presence. Professionals eager to teach but not prepared to learn from families may fail to acknowledge parents' expertise and competence (Knapschaefer, 1987; Thomas, 1987). Furthermore, the focus on what is "wrong" with the child, both medically and developmentally, may result in inadequate attention to the child's strengths and areas of health. Professionals may contribute to what Green and Solnit (1964) described as the "vulnerable child syndrome," in which some parents persist to a pathological degree in perceiving their child as sickly or vulnerable following an illness in infancy or toddlerhood, despite a full and satisfactory recovery.

Behavior of hospitalized infants and toddlers

Infants and toddlers who experience lengthy or repeated hospitalization often demonstrate certain behavioral qualities. These may include:

- social and exploratory passivity;
- an inhibited perception of their ability to move beyond immediate physical space (e.g., reaching for a toy requiring a slight stretch from a stable sitting position, or crawling once a quadruped position can be sustained);
- a narrow range of affective expression that may be limited to irritability or, just as likely, to the consistently jovial behavior that is reinforced by staff;
- distractibility;
- disinterest in fine motor tasks that require eye-hand coordination, and preference for a limited repertoire of gross motor schemata that allow the child to wave, bang, shake and mouth toys while visually scanning the environment;
- persistent mouthing of toys despite developmental maturity that would suggest the decrease or elimination of this form of exploration (particularly notable in infants and toddlers with tracheostomies, even if receiving oral nutrition, and in those who do not receive a significant portion of their nutrition orally); and
- notably minimal vocalizations and few attempts at intentional verbal communication.

The long-term developmental effects of hospitalization during infancy and toddlerhood have been explored by Douglas (1975), Dowling (1977), Quinton and Rutter (1976), Schaffer and Callender (1979), McDonald (1981) and Meijer (1985). The complex

interactions that occur between the hospitalized infant and the caregiving environment may best be illustrated by several case examples from a pediatric tertiary care center.

Shantal, now four months old, was born more than 10 weeks prematurely to a drug-abusing mother from whom she inherited both HIV antibodies and cytomegalovirus. She has a tracheostomy and bronchopulmonary dysplasia remaining from her extended requirement for a respirator. She may or may not develop symptoms of AIDS, but she is becoming medically stable.

Shantal's mother is increasingly ill, and no other family members visit the child. Despite the affection shown Shantal by her primary nurses, often no one is available to interact with her and optimize her experience during her brief naturally occurring awake and alert times. Since hospital policy requires her isolation from other patients, Shantal cannot even watch the pleasurable activity of the playroom. Finding a foster home is a challenge.

Frank developed necrotizing enterocolitis soon after birth, and has required significant and repeated abdominal surgery plus additional surgical procedures for placement of special intravenous catheters to enable the provision of total intravenous nutrition. In the six months of his life he has not had a single oral feeding. His parents visit each evening, but must work in the daytime to maintain their modest income and insurance coverage. As a result, Frank stays awake late at night but is sleepy during the day when nurses, physicians, therapists and nutritionists must evaluate his progress and provide their interventions. When they awaken Frank, these professionals may offer reasons: "He shouldn't be asleep at this time of day"; "He probably just fell asleep"; "He will probably wake up soon anyway"; "He won't mind"; and "It would be hard for me to come back to this unit later." Sometimes Frank is irritable. Some professionals consider him "lazy" or "spoiled."

Jasmine is now 14 months old and has been on our unit her entire life. Her prognosis is guarded, and she will likely be on our unit for many more months. She to has never received oral nutrition. Each nurse, doctor, housekeeper, therapist, parent, and transport aid who has ever had contact with Jasmine is drawn to her smiles and "cute" responses. As each one passes her room, he or she calls out an affectionate greeting or stops for a quick hug or tickle. Jasmine smiles, calls back some enchanting response, and continues to play, never once looking at her hands and always scanning the hall for the next "friend." Each passerby loves her in his own way, and eagerly accepts Jasmine's generous social rewards. Jasmine gives people pleasure in their day. Some of these friends are known to give her secret licks of lollipops and other tastes, although her sensitive gut will not tolerate even slow, tiny drops of Pedialyte given through her gastrostomy tube. Her father, who has returned to his native country, would prefer her mother not to be involved with this sick female infant, who has many strikes against her according to their cultural and religious values. So family rarely visits Jasmine, and nurses love her as their own.

Sandi is particularly worrisome. She is a five-month-old, now hospitalized for the second of what will probably be many hospital admissions. She has significant orthopedic and neurological anomalies, and is failing to thrive despite much medical intervention. Sandi will have several persisting areas of handicap despite intellectual capacity that seems within normal limits.

Sandi's mother has a three-year-old to care for, but travels nearly an hour each way three or four times per week as often as her own mother can babysit to visit for several hours. Sandi's father is increasingly backing off and the marriage is increasingly rocky. Mom seems to be a real fighter, a devoted mother who will find a way for Sandi, and a way for herself, too, if need be.

When her mom has been with her Sandi has enough energy to look around the room and smile spontaneously at a very few familiar faces, and to reach for lightweight toys. Sometimes she even coos. But the therapist who visits in the morning, when mommy is never there, doesn't get to see this. She sees Sandi as irritable (which she is). Right now Sandi is not eating by mouth. She is ravenously hungry and somewhat hard to console. She gets her primary comfort from sucking vigorously on her pacifier. She tends to turn away from caregivers, and sometimes looks rather limp and dazed when she is held. So Sandi is not a favorite, and does not have, like her roommate Jasmine, a long line of people eager to nurture her.

Strategies for care

In this writer's experience the developmentally worrisome behaviors of hospitalized infants and toddlers are largely eliminated as significant problems when parents persist in providing daily, mutually gratifying interaction. Thus the foremost goal of psychosocial services to families should be encouraging parents' positive perception of their infants and involvement in their daily care. Unfortunately, as this is often not possible, professional staff must take special pains to address and to compensate for the effects of medical treatment.

One avenue of support for the development of hospitalized young children is through coordinated interdisciplinary care. "Interdisciplinary" is a hospital catchword of the 1980s. It often seems that the more consultants involved, the more people feel that the hospital is "doing something" for a child. However, interdisciplinary care can sometimes mean too many strangers to whom the infants must adapt or respond; too many strangers giving parents information or advice, or competing for the child's attention; days organized to fit caregivers' schedules rather than the infant's rhythms and patterns; and overwhelming, ever-changing numbers of caregivers, whose agendas may be in competition with sick infants' needs for attachments, rhythm predictability, intrinsic motivation, and emerging independence.

Genuinely interdisciplinary care should be noncompetitive with parents; should encourage parents' role as the ultimate coordinators of the team on behalf of their child; should reinforce parents' perception of their infant's areas of health as well as illness; and should also reinforce parents' perception of their own strengths. Nursing, child life and rehabilitation therapies should enhance the infant's emerging capacities for rhythmicity, attachment, pleasure, and self-motivated and successful activity, and balance predictable daily patterns with interesting novel events. Optimal interdisciplinary care should be carried out through consistent care patterns, performed by as few, rather than as many, different professionals as possible. Staff should be educated to engage in responsive, interactive social play rather than intrusive, interrupting play.

In addition, play can address emotional or developmental needs both preventively and remedially (Goldberger, 1988). Play can be used *preventively* to facilitate enjoyable parent-infant interaction, to aid parents in perceiving their infant's capabilities, to provide developmentally appropriate opportunities, and to structure time to order to both minimize stressful or fearful anticipation and provide normalizing experiences. Preventive play might include planning a child's care and medication to be grouped together to provide long, uninterrupted blocks of time for play and naptime. A three-month-old requiring arm restraints, for example, could then be supervised in a play setting without restraints and with ample opportunity for reaching and grasping; a child life specialist or nurse might facilitate hiding and finding games for a toddler prior to a parent's departure. Play can be provided *remedially* to aid in establishing predictable, enjoyable rhythmic patterns; to address problems created by the medical environment, such as passivity, incorporation of medical

equipment in body image, channelling anger and frustration; and to provide preparation and desensitization for medical and surgical experiences. A very few examples of remedial play might include directed throwing games to reduce tension in confined toddlers, doll play with medical tubing and familiar equipment specific to a child's medical experience, and use of mirrors and stroking to aid children in acquainting themselves with the parts of their body obscured by medical equipment (for example infants on respirators may not be able to see their feet, or even hands) in order to begin to reach for and explore them.

Let us now return to Shantal, Frank, Jasmine, and Sandi to see how we might be able to enhance their care.

Shantal. Our hospitals are filling with Shantals. We need to recall the insights of Spitz (1945), and of Provence and Lipton (1962), concerning the grim prognosis for infants and toddlers who receive adequate or excellent physical care in the absence of adequate emotional nurturing. Shantal needs consistent caregivers to enjoy her and to delight in her achievements. While she awaits a foster home, primary nursing and child life care can help Shantal to establish relationships and maximize her still brief periods of alert attention. Because stringent cost-containment policies have staff stretched to their limit, with too little time remaining for truly adequate attention to Shantal's social and emotional needs, a foster grandparent program could help greatly, although legal questions regarding confidentiality of patient diagnoses along with volunteers' rights to make an informed choice regarding contact with patients who test positively for AIDS antibodies complicate that solution. Policies encouraging more generous staff-to-patient ratios for children in isolation would be ideal.

Frank. A care plan that follows Frank's sleep and waking patterns would be likely to maximize his interest and performance, and to increase the mutual enjoyment and gratification of child and staff in interaction. Several times daily, and ideally as often as his parents would like, the experience of feeding in an age-appropriate manner should be imitated as closely as possible. Even a few milliliters of Pedialyte could continue oral experience and sucking and swallowing, as could holding, cuddling and encouraging Frank to suck on a pacifier with a nipple whose shape is the same as the nipple that will be used for feeding. Again, precious staff time should ideally be used to provide such normalizing experiences in addition to essential medical care.

Jasmine. Pediatrician Arthur Parmelee (cited in Goldberger, 1987) requires that his staff interact with a hospitalized infant or toddler for at least 15 minutes; if staff can't spend that much time, they must come back when they can. Such a rule would be a creative solution to the innumerable, intrusive and overstimulating brief interactions imposed on "favorite" patients such as Jasmine. With her medical complications, Jasmine could have been identified soon after birth as at risk for extreme lack of oral experience, extreme learned passivity, daily challenges to her ability to learn to concentrate, and impoverished language opportunities. There is little we could do to prevent the consequences of repeated surgical procedures, which seem to occur just when she has become interested in or begun to master a new skill, and causing her to need to begin afresh after each surgery. We might concentrate on alternate ways of reaching beyond her immediate sphere and her motivation to be an active, problem-solving participant rather than a passive recipient of developmental stimulation. Toys with high rewards might facilitate this interest, but, again, responding contingently to her cues and behaviors would be an even more significant focus. Perhaps someone other than hospital staff might reach her parents more satisfactorily, such as a religious leader who might support their increased involvement. If not, better education and emotional support for staff might help staff channel

their anger and frustration at Jasmine's family's infrequent visits, and gain respect and understanding of their fears, inexperience, beliefs and cultural differences that are influencing their behavior.

Sandi. Even were she healthy, Sandi would probably be emotionally fragile. She is at her best when her mother is available: what can we do to maximize her mother's ability to be present? Hospital based day care for siblings? Counseling to address the family's increasing tension, which is often focused on whether or not Sandi should come home or be included in family holiday events? A parent-support network that encourages parents of children and similar handicapping conditions to encourage and learn from each other?

Sandi is beginning to enjoy social contact, particularly from a distance and if touching is not involved. At those times when Sandi is offered oral feedings, she will drink while she is being held by the few people who enjoy caring for her; she will refuse feedings, no matter how hungry she seems, when they are offered by someone who does not enjoy caring for her. It should become part of her primary nurses' and child life care plans to respect Sandi's comfort level as much as possible, and move toward her slowly. Recently she has begun to tolerate a caregiver sitting next to her without her looking away. Even though she may not look at a favored caregiver, she least may not appear pale and limp when her arms are stroked. Cute clothes may help staff feel attracted to this infant, who is minimally interested in people and who is not enjoyed by most of the hospital staff.

Not long ago, a caring therapist expressed concern that when she tried to interact with Sandi after therapy, the infant did not visually track either her or a toy nor did she turn to sound. (At that moment, in fact, Sandi was using her energy to search for her pacifier which she could not successfully maneuver to her mouth because of the IV in her arm.) It was a new idea to this very kind, very concerned therapist (and to the student who wanted to try a black-and-white stimulation kit to improve Sandi's visual tracking) that Sandi might not be watching them because she was too tired, hungry, stressed, and probably hurting to reach beyond whatever small, but predictable, comforts she could provide herself. It was new for the therapist to think of motor skills as so closely linked with emotional response.

Now Sandi is capable of and interested in reaching and grasping toys. We must provide opportunities with adequate complexity, variety, satisfaction, and interest, along with caregiving so that she will learn to enjoy people, to be interested in the world, to concentrate, and to pursue her own goals even in the hospital environment.

Conclusion

In these days of rapidly advancing medical technology and decreasing availability of and priority to psychosocial services, it will be a challenge to match the quality of emotional care to the quality of technical care. In addition, parameters for optimally supportive care for infants and toddlers in hospitals need further definition and demonstration. Staffing and services should aim to reflect more attention to quality of life rather than short-sighted financial constraints, and those responsible for the delivery of care should strive to understand infants' priorities and make them their own.

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6

Mediating Successful Parenting: Guidelines for Practitioners

Serena Wieder, Ph.D.

Parents learn to be parents in many ways. Some read books, pamphlets or magazines available at every checkout counter. Others watch TV talk shows, talk to their friends or neighbors, call their mothers, or remember their own childhoods. Still others take courses and join other new parents. Hopefully, all learn from their infants as they care for them, enjoy them, and grow together.

At-risk parents are often unable to use these resources to learn. They may be distressed by overwhelming realities, overwhelming pasts, and previous failures and fears which continue to interfere with their functioning in general, and as parents in particular. Too often they do not have the chance to enjoy what other parents enjoy with their children: singing songs, dressing up, taking pictures, or playing.

Whatever the structure or goals of an intervention program, working with these parents and infants involves interacting and relating in many ways. Specific techniques are described below to mediate more successful parenting. They are derived from therapeutic and mediated learning experience models which can be integrated into common interactions and play during time spent together.

Give the concept of being a mother or father positive meaning and identity—build consciousness and awareness of being a parent. It is important not to assume that having a child means feeling like a parent. Even if someone begins to feel like a parent, nurture this new identity with as much support as possible. This is done by admiring the parents, giving them credit for what they do, having fun together with the infant, and reassuring them the child is doing well. To do this, indirect comments are useful. For example, when seeing a baby who is dressed nicely or is attractive, one might say to the baby being held by the mother, "Mommy dressed you so beautifully today; she knows exactly what looks good on you!" Or, "You're so big, Mommy knows exactly what/how to feed you to make you grow!" Or, "Mommy knows how to dress you beautifully Suzy, you're a lucky girl!" Or, "What an athlete Daddy is making out of you." Such comments help a parent feel proud, focus on the process of what they have to do to feel competent, and lessen the risk of parental jealousy of the infant. One does not assume the parents appreciate or take pleasure in having their child admired when they are not directly credited or referred to.

Make the mother and father feel unique. To support the special attachment and investment parents need to make in their infants, reinforce the uniqueness of the parent to the child. This too can be done through a variety of comments to the parent, such as, "Mommy gets the best smiles from you; I know who is in love with you!" as the baby smiles at the parent. Similarly, when noting the baby looking at a new or strange face, say ,"You sure know your mommy best of all because I can see you

staring at me and you don't know me at all!" In the course of following an infant, many opportunities arise which can highlight the parents' unique function. For example, when a baby fusses, the intervenor might say, "Mommy will know how to comfort you best of all," as you guide or support the parent's response to calm the infant. Here too is an opportunity to give the parents credit for anything they do, for the purpose of enhancing their special relationship with the child and supporting their self-esteem.

Focus on the infant's or parent's experience rather than right or wrong. It is possible to communicate to the parent that infants have feelings and experience things in different ways through straightforward comments or "talking through the baby." For example, one might say "Hold me tight; I like to be all wrapped up tightly too." Or, "Don't turn me so fast; it's scary and I'm afraid I'll fall." Noticing how the infant might be feeling is especially important for the parent who does not empathize readily, or does not think in terms of the infant's feelings, or may not be handling the baby very well and does not notice the effect she or he is having. Such comments support the parent's efforts without the practitioner's taking over or necessarily knowing what is going to work best. This approach encourages exploring different attempts to calm the baby by reading signals with the parent and relating to these signals as expressions of feelings.

Focus on issues relevant to the infant's specific stage of development. For example, when helping parents learn to read the baby's cues and signals as they begin to communicate in purposeful ways, highlight the meaning of these behaviors. For example, "You want to tell mommy something, don't you?" Or, "Figuring out what you want isn't easy at all; tell/show mommy what you want again." "Oh, look how he turns around to look at you just after he crawled away; he wants to make sure you're still there!" "Boy, you need your daddy's help, don't you, it's hard!" Such comments accomplish multiple things. They focus on what is important for the parent to respond to at specific stages. They preempt misinterpretations of the meaning of behavior which can lead some parents to withdraw or reject or retaliate against their children if they disapprove. It is also easier for parents to learn an infant's language if they feel it is directed towards them. These comments support the attachment, identity and uniqueness of the parent.

Focus on the impact of current behavior on the future. With parents who do not relate current development to later achievement or success, or parents who have little sense or hope for the future because of being overwhelmed in the present, it is useful to create a sense of future success for the infant and the role parents can play. For example, when encouraging reading baby books, you might say, "When you grow up, you will be so smart because mommy is getting you ready already!" Or, when observing a child play with blocks, "I wonder if you will be an engineer or an architect, you build those blocks so well!" Or, "Daddy is so good with tools and you are following his footsteps already." Encouraging the ability to transcend the present is important so that parents identify infant learning with future success in school or work. But it is important to focus on the process of learning and not the product, i.e., discovering, exploring, trying new things, using toys or objects in novel ways, rather than being able to name letters, numbers and other concrete skills.

Build parental self-esteem by selecting and admiring success. Whenever a child is doing something well, it is worthwhile pointing that out and building an image of the child as a successful learner and the parent as a successful parent who can be effective and help the child learn. General admiration or clapping such as, "That's great!" or "You're so good!" is not as useful as specifying what made the act successful or what difference it makes. For example, if a toddler is stacking rings, then he might

be admired for, "you figured out which one should come first and second and thirds, that's good thinking!" Even if the child cannot yet understand these words, commenting guides the parent to think in terms of thinking and problem solving rather than just the end product which may or may not be well done. Focusing on the process of how or why something succeeds encourages the parent to pay attention to what to do, rather than what they will get or other concrete results. For example, admire the parent's success in getting the child to attend. "You really got him to listen when you got him to look at you before telling him what to do." When these behaviors are noticed in the course of natural interaction they convey the idea learning is going on all the time. They also put the parent in charge and reinforce effective behaviors rather than only focusing on problems and parents' inadequacies.

7

The Developmentally Designed Group Care Setting: A Supportive Environment for Infants, Toddlers and Caregivers

Louis Torelli, M.S.

The physical environment in a group care setting affects children, caregivers, and their interaction. A well-designed environment is, of course, safe for infants and toddlers, but it also supports their emotional well being, stimulates their senses and challenges their motor skills. A well designed group care environment promotes children's individual and social development. It is comfortable and aesthetically attractive to both children and their caregivers.

A developmental environment is designed specifically to promote learning that is both age appropriate and child-directed. The setting, layout and equipment all give infants many opportunities to challenge themselves through seeing, touching, feeling and moving. In surroundings that are safe to explore freely, infants learn to map their environment cognitively, to manipulate it, and to master it.

In group care classrooms without a developmental design, one generally observes young children spending a significant amount of time in either aimless wandering or teacher-directed activities. Because making friends is a social skill that depends on experience as well as age, a group care environment that is teacher-directed can deprive infants and toddlers of opportunities to enjoy positive interaction with their peers. Consider a toddler classroom where the teacher takes out baskets of *Duplos*, brings them to the middle of the room, and sits on the floor surrounded by ten toddlers—all shoulder to shoulder. After only a minute or so, one child grabs another's Duplos. While the teacher encourages this pair to "be gentle," the same battle is beginning between two other children. Then a toddler who has been racing around the classroom suddenly runs to the middle of the room and kicks the tower of another child who has been deeply involved in play.

In contrast, a developmentally designed environment offers infants and toddlers choices of activities and opportunities to break away from the larger group. A multi-level design, for example, varies the floor height with appropriately scaled platforms, lofts, "nests" and canopies. These mini learning environments set up a landscape for safe exploration in which infants can handle a toy, look at a book, stack blocks, crawl up steps, or simply watch the adults and other children from a cozy semi-enclosed "private space."

For toddlers, a developmental design would also include an area for manipulative play with *Duplos*, shape sorters, pop beads, and the like. Such an area would be enclosed by shelves, low walls, or carpeted platforms. Because this would be one of several activity areas available, toddlers could choose themselves when they wanted to engage in this kind of experience and for how long.

Mini learning areas encourage privacy and small-group interaction rather than wandering and herding. In smaller groups, young children can be intensely involved with each other. In an environment that encourages focused play in small groups, relationships among children are less aggressive and more supportive.

After her classroom was redesigned according to developmental concepts, a toddler teacher summarized the differences for children and for herself:

"You can feel the difference when you walk in the room. It's so much more comfortable! Instead of moving around aimlessly, the kids are much more focused on activities. Now they can be active in the classroom without getting into each other's space. Instead of climbing on furniture, they have a place to climb.

Having all this storage makes me a much more organized teacher. In a way I really feel spoiled. But then I think, the kids deserve this, and I deserve this.

It makes me feel so happy."

Let us consider some specific elements of a well-designed group care environment for infants and toddlers.

Layout

Create mini-learning environments by placing multi-level activity areas around the periphery of the classroom. This leaves the middle of the room open for traffic lanes and "stage set" activities such as music and movement experiences. The open central section itself can be varied by using portable equipment such as carpeted risers and bolsters.

Motor challenge

Because motor activity is critical to the overall development of infants and toddlers, the physical environment must provide safe and appropriate motor challenges. A developmentally designed environment supports ease of movement, which then encourages active exploration.

Contrast an environment that encourages climbing, crawling, running and jumping with one that does not. The need to move still exists, but the environment does not support this need. When the setting lacks appropriate equipment, the ten-month-old still moves, but she uses the high chair to pull up to standing and then is redirected because this is not safe. The eighteen-month-old attempts to use the toy and book shelf as a climbing apparatus, but he too is redirected. The two year-old who continually gets up on the table to jump off is redirected as well. The message to these children is: "Self-initiated exploration is not acceptable."

But an environment designed to meet infant and toddler needs supports and encourages active exploration. The children get the message that it is fine to explore and take risks here. Their motor exploration leads to motor competence, which then contributes to emotional well-being.

The role of equipment

Appropriate equipment is essential to meet the motor needs of infants and toddlers in group care. Equipment also affects peer relationships significantly. For example, equipment that may be ideal for individual development may be a burden in a group care environment. And since the field of group infant care is in its own infancy, choices of commercially available equipment are still limited.

Consider the infant ladder-slide found in many child care centers. Older infants and toddlers love to use it, but only one child at a time can play on it. In order for children to use this slide safely, the caregiver must police it, having children wait their turns and redirecting those who have difficulty doing so.

If the equipment were designed to allow more than one child to use it simultaneously, the situation would no longer be stressful for either children or caregiver. Toddlers could be more actively involved in motor exploration, and they would also have an opportunity for positive peer interaction. Instead of controlling and redirecting, the caregiver could be observing, learning more about the infants in her care.

Flexibility for mixed age groups

Mixed age groups present a particular challenge. The environment must support the motor interests of older infants and toddlers while providing safe, relaxed care for young infants.

Shelving, low walls, large pillows, mats, platforms and portable risers can all be used to separate different activities and thus respond flexibly to the diverse needs and interests of a mixed age group. When the whole group is in the room, the caregiver can enclose a corner with a few portable risers. Younger infants will be safe in this protected space with a caregiver, while the older infants and toddlers move freely around the classroom. When half the group is outdoors or several infants are napping, the caregiver can redesign the space to allow for more open play and movement.

Using storage for flexibility

Every activity area in the classroom—for eating, manipulative, art, books, blocks, etc.—should have its own storage space. To reserve as much space as possible for children's use, locate storage space on the walls, at a height of 48 inches or more.

Infant/toddler caregivers inevitably spend much of their time changing diapers. Well-designed storage in diaper changing areas can leave the caregiver available to engage in responsive interaction with the child during diaper changing.

Mental health

A developmentally appropriate space is designed to be emotionally supportive for both children and adults. The setting encourages relaxation. It invites one to spend time.

Track lighting, carpeting, pillows, textured wall hangings, plants and animals can all contribute to a comfortable environment. Photographs of children and family members; wide, full-length plexiglass mirrors; and hammocks for rocking infants all offer emotional support. (Hammocks work better than rocking chairs because they allow the caregiver to rock more than one infant at a time if necessary. Rocking chairs can seriously hurt an infant who crawls behind one in motion; they also take up floor space.

while hammocks can be taken off their hooks and stored when not in use.)

Windows—especially those that open and look out to trees, grass, and passersby—contribute to a relaxed setting. Because older infants and toddlers love to watch others, child-level windows that look into another classroom can function as an additional learning center.

Privacy

Being alone provides time essential for reflection and growth. Although most adults recognize the need for privacy, we often expect infants and toddlers to function well in group care situations for upwards of ten hours a day, five days a week. Private spaces in the group care environment support the development of the young child's self-concept and personal identity. They assist all ages in understanding the "I" in relation to the "thou."

A private space could be a tunnel, a carpeted built-in cabinet with the doors removed, a cozy loft space, or a few risers enclosing a small corner of the room. Instead of experiencing the stress of being in a large group all day, the infant can withdraw to a private space to rest, observe, and recharge emotionally. With access to a private space, two toddlers who are just beginning to develop a relationship can go off together. Opportunities for privacy not only support the infants' developing sense of self; they also reduce aggression among children.

The people in the environment

While a developmentally designed environment adds significantly to the quality of group care for infants and toddlers, other components of care are equally critical. While considerable attention has been paid to adult/child ratios, caregiver training and parent involvement, group size has still not been recognized uniformly as a key variable in quality care. A decade ago the National Day Care Study (Ruopp, 1979) found that too many children and adults grouped in one space affected relationships adversely. When more than seven infants or eleven two-year-olds were cared for in a group—even with one adult for three infants and one adult for four two-year-olds—observers saw more crying, hostility, and apathy and less cooperation, reflection and elaborate play than in smaller groups. In large groups, the infant experiences sensory overload and has a harder time forming a close relationship with a specific caregiver; forming a group identity is difficult.

Conclusion

A developmentally designed environment offers infants and toddlers opportunities to explore, make choices, and master their world. It offers caregivers a chance to be observers, facilitators and supporters of all aspects of development in the early years. A well-designed child care environment not only reassures families but invites them. When an environment is designed to be functional, attractive and developmentally supportive, everyone feels well cared for.

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Zero to Three: A Topical Index for Volumes I through XII

This index groups by topic the articles and reviews of publications that appeared in *Zero to Three* from September, 1980 through June, 1992. When an item is listed as "review of," this means that a brief summary of the publication appears in the issue of *Zero to Three* indicated.

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ADOLESCENTS

Anastasiow, Nicholas
The Adolescent Parent/Review of
Vol. 4, No. 5, June 1984, p.14

Baskin, Cathy, Umansky, Warren and Sanders, Wendy
Influencing Responsiveness of Adolescent Mothers to their Infants
Vol. 8, No. 2, December 1987, p.7

Frank, Daniel
Dirty Blue Funk & Other Stories.—Portrait of Teenage Parents/Review of
Vol. 4, No. 1, September 1983, p.13

Furstenberg, Frank Jr., Brooks-Gunn, J. and Morgan, S. Philip
Adolescent Mothers in Later Life/Review of
Vol. 8, No. 5, June 1988, p.27

Guttmacher Institute
Teenage Pregnancy: The Problem That Hasn't Gone Away/Review of
Vol. 1, No. 4, June 1981, p.13

Hayes, Cheryl, ed.
Risking the Future: Adolescent Sexuality, Pregnancy and Childbearing, Volume I/Review of
Vol. 8, No. 2, December 1987, p.22

Henderson, Barbara Joan
Perspectives on Practice: Carol, Melvin and Yolanda
Vol. 8, No. 2, December 1987, p.12

Kalmanson, Barbara and Lieberman, Alicia
Case Report: Removing Obstacles to Attachment: Infant-Parent Psycho-Therapy with an Adolescent Mother and Her Baby
Vol. 3, No. 1, October 1982, p.10

Lancaster, Jane B. and Hamburg, Beatrix A., eds.
School-Age Pregnancy and Parenthood: Biosocial Dimensions/Review of
Vol. 7, No. 5, June 1987, p.32

Marcus, Joseph and Auberey, Annie
Multidimensional Statistical Analysis: A Partner for Clinical Insight
Vol. 3, No. 1, October 1982, p.1

McAnarney, Elizabeth, ed.
Premature Adolescent Pregnancy and Parenthood/Review of
Vol. 4, No. 5, June 1984, p.13

McAnarney, Elizabeth and Schreider, Corinna
Identifying Social and Psychological Antecedents of Adolescent Pregnancy: The Contribution Research to Concepts of Prevention/Review of
Vol. 6, No. 3, February 1986, p.15

McGee, Elizabeth
Too Little, Too Late: Services for Teenage Parents/Review of
Vol. 4, No. 5, June 1984, p.14

Miller, Shelby
Children as Parents: Final Report on a Study of Childbearing and Child Rearing Among 12-15 Year Olds/Review of
Vol. 4, No. 5, June 1984, p.13

Musick, Judith; Bernstein, Victor; Percansky, Candace and Stott, Frances
A Chain of Enablement: Using Community-based Programs to Strengthen Relationships between Teen Parents and Their Infants
Vol. 8, No. 2, December 1987, p.1

Nickel, Phyllis Smith and DeLaney, Holly
Working with Teen Parents: A Survey of Promising Approaches/Review of
Vol. 5, No. 5, June 1985, p.18

Pittman, Karen and Adams, Gina
Teenage Pregnancy: An Advocate's Guide to the Numbers/Review of
Vol. 9, No. 2, December 1988, p.22

Smollar, Jacqueline and Ooms, Theodora
Young Unwed Fathers: Research Review, Policy Dilemma and Options, Summary Report/Review of
Vol. 9, No. 5, June 1989, p.26

ADOPTION

Argenta, Deane
And Baby Makes Two: Adoption and the Single Parent
Vol. 10, No. 5, June 1990, p.9

Arms, Suzanne
Adoption: A Handful of Hope/Review of
Vol. 10, No. 5, June 1990, p.26

Brazelton, T. Berry
On Adoption
Vol. 10, No. 5, June 1990, p.5

Frank, Elaine and Rowe, Denise
Preventive Intervention Groups with Adoptive Parents and Their Babies: Minimizing the Risks to Emotional Development in the First Three Years
Vol. 10, No. 5, June 1990, p.19

National Committee for Adoption
Adoption Factbook: United States Data, Issues, Regulations and Resources/Review of
Vol. 10, No. 5, June 1990, p.25

Roles, Patricia
Saying Goodbye to a Baby, Volume 1, The Birthparent's Guide to Loss and Grief in Adoption and Volume 2, A Counselor's Guide to Birthparent Loss and Grief in Adoption/Review of
Vol. 10, No. 5, June 1990, p.26

Schiff, Albert J. and Nordhaus, Barbara
Adoption
Vol. 10, No. 5, June 1990, p.1

Williams, Anne
The "Psychological Work of Pregnancy" in Adoption
Vol. 10, No. 5, June 1990, p.13

ASSESSMENT

Brazelton, T. Berry
Assessment As a Method For Enhancing Infant Development
Vol. 2, No. 1, September 1981, p.1

Brown, Catherine Caldwell and Gottfried, Allen, eds.
Play Interaction: The Role of Toys and Parental Involvement in Children's Development/Review of
Vol. 5, No. 3, June 1985, p.19

Chamberlain, Robert W., ed.
Beyond Individual Risk Assessment: Community Wide Approaches to Promoting the Health and Development of Families and Children/Review of
Vol. 9, No. 3, February 1989, p.25

Children's Charter of the Courts of Michigan and Michigan Association for Infant Mental Health
Guidelines for Assessing Parenting Capabilities in Child Abuse and Neglect Cases/Review of
Vol. 7, No. 4, April 1987, p.23

Editors
Measuring Depression Through The Use of Specific Criteria: The Kiddie Infant Depression Observation Scale
Vol. 3, No. 4, July 1983, p.9

Haynes-Seman, Claire and Hart, Joan Suzuki
Doll Play of Failure to Thrive Toddlers: Clues to Infant Experience
Vol. 7, No. 4, April 1987, p.10

Kochanek, Thomas T.
Conceptualizing Screening Models for Developmentally Disabled and High Risk Children and Their Families
Vol. 9, No. 2, December 1988, p.16

Lamb, Michael E.; Thompson, Ross; Gardner, William and Charnov, Eric
Infant-Mother Attachment: The Origins and Developmental Significance of Individual Differences in Strange Situation Behavior/Review of
Vol. 8, No. 2, December 1987, p.22

Meisels, Samuel J. and Provence, Sally
Screening and Assessment: Guidelines for Identifying Young Disabled and Developmentally Vulnerable Children and Their Families/Review of
Vol. 10, No. 2, December 1989, p.26

Thomas, Robin B. and Barnard, Kathryn E.
Understanding Families: A Look at Measures and Methodology
Vol. 6, No. 3, June 1986, p.11

Turner, Carolyn S.
Qualitative Assessment of Infants and Young Children
Vol. 6, No. 3, June 1986, p.10

Wachs, Theodore D. and Sheehan, Robert, eds.
Assessment of Young Developmentally Disabled Children/Review of
Vol. 9, No. 1, September 1988, p.28

Zelle, Raenene and Coyner, Athleen
Developmentally Disabled Infants and Toddlers: Assessment & Intervention/Review of
Vol. 4, No. 2, December 1983, p.15

CHILD ABUSE & NEGLECT

Bross, Donald C., Krugman, Richard D., Lenherr, Marilyn R., Rosenberg, Donna Andrea and Schmitt, Barton D., eds.
The New Child Protection Team Handbook/Review of
Vol. 9, No. 3, February 1989, p.25

Browne, Kevin; Davies, Cliff and Stratton, Peter, eds.
Early Prediction and Prevention of Child Abuse/Review of
Vol. 9, No. 3, February 1989, p.25

Children's Charter of the Courts of Michigan and Michigan Association for Infant Mental Health
Guidelines for Assessing Parenting Capabilities in Child Abuse and Neglect Cases/Review of
Vol. 7, No. 4, April 1987, p.23

Cicchetti, Dante and Toth, Sheree
The Application of a Transactional Risk Model to Intervention with Multi-risk Maltreating Families
Vol. 7, No. 5, June 1987, p.1

Coleman, Loren; Partridge, Susan and Partridge, Roy
Unattended Children/Review of
Vol. 8, No. 3, February 1988, p.27

Garbarino, James; Brookhauser, Patrick E. and Authier, Karen J.
Special Children-Special Risks: The Maltreatment of Children with Disabilities/Review of
Vol. 7, No. 4, April 1987, p.11

Gelles, Richard and Lancaster, Jan, eds.
Child Abuse and Neglect: Biosocial Dimensions/Review of
Vol. 9, No. 2, December 1988, p.24

Horacek, Joseph H.
Psychotherapy of the Violent Offender: A Recapitulation of Infant Development
Vol. 7, No. 4, April 1987, p.15

MacFarlane, Kee and Waterman, Jill
Sexual Abuse of Young Children: Evaluation and Treatment
Vol. 7, No. 4, April 1987, p.22

National Committee for Prevention of Child Abuse
Various publications/Review of
Vol. 7, No. 4, April 1987, p.13

Pawl, Jeree
Infant Mental Health and Child Abuse and Neglect: Reflections from an Infant Mental Health Practitioner
Vol. 7, No. 4, April 1987, p.1

Steele, Brandt F.
Abuse and Neglect in the Earliest Years: Groundwork for Vulnerability
Vol. 7, No. 4, April 1987, p.14

CHILD CARE

Infant Day Care Researchers: Consensus on Social Policy Issues
Vol. 8, No. 3, February 1988, p.27

Ad Hoc Day Care Coalition
The Crisis in Infant and Toddler Child Care/Review of
Vol. 6, No. 2, December 1985, p.16

Adams, GC
Who Knows How Safe? The Status of State Efforts to Ensure Quality Child Care/Review of
Vol. 11, No. 3, February 1991, p.34

American Academy of Pediatrics
Health in Day Care: A Manual for Professionals/Review of
Vol. 7, No. 5, June 1987, p.33

Association for the Care of Children's Health
Home Care for Children with Handicapping Conditions/Review of
Vol. 5, No. 4, April 1985, p.21

Alston, Frances Kemper
Caring for Other People's Children: A Complete Guide to Family Day Care/Review of
Vol. 4, No. 4, April 1984, p.17

Antmann, Annette
The Center for Infants and Parents at Teachers College, Columbia University: A Setting for Study and Support
Vol. 4, No. 3, February 1984, p.4

Balaban, N
Mainstreamed: Mixed-age Groups of Infants and Toddlers at the Bank Street Family Center
Vol. 11, No. 3, February 1991, p.13

Barglow, Peter
Some Further Comments about Infant Day Care Research
Vol. 7, No. 5, June 1987, p.26

Belsky, Jay
Infant Day Care: A Cause for Concern?
Vol. 7, No. 1, September 1986, p.1

Belsky, Jay
Risks Remain
Vol. 7, No. 3, February 1987, p.22

Bentzen-rad, Sonya
Promoting and Safeguarding Early Relationships in Child Care: The Child Care Dallas Family Day Home System
Vol. 10, No. 3, February 1990, p.10

Blank, Helen; Williams, Amy and Crawley, Margaret
State Child Care Fact Book: 1987/Review of
Vol. 8, No. 3, February 1988, p.27

Bond, James T.
Volunteer Research and Action: Mothers in the Workplace
Vol. 8, No. 5, June 1988, p.22

Bonnes, Anthia
Marginally Learning Disabled Young Adults: Competent Caregivers for Infants?
Vol. 4, No. 3, February 1984, p.11

Bradekamp, Sue, ed.
Developmentally Appropriate Practice/Review of
Vol. 7, No. 2, December 1986, p.17

Brazelton, T. Berry
Working and Caring/Review of
Vol. 6, No. 3, February 1986, p.13

Bruder, Mary Beth; Deuner, Penny and Sachs, Sandy
Models of Integration Through Early Intervention/Child Care Collaborations
Vol. 10, No. 3, February 1990, p.14

Chehrazi, SS, ed.
Psychosocial Issues in Day Care/Review of
Vol. 11, No. 4, April 1991, p.31

Chess, Stella, M.D.
Comments: "Infant Day Care: A Cause for Concern"
Vol. 7, No. 3, February 1987, p.24

Child Care Action Campaign
Child Care Action Campaign Media Kit/Review of
Vol. 7, No. 1, September 1986, p.18

Clark, Roseanne and Ottmans, Mary Jane
"The Sooner the Better Project": Involving Parents and Day Care Staff in the Identification and Treatment of Developmental Delays and Disturbances in Infants and Toddlers
Vol. 7, No. 1, September 1986, p.10

Comfort, Randy Lee and Williams, Constance D.
The Child Care Catalog/Review of
Vol. 7, No. 5, June 1987, p.34

Copeland, Tom and Roach, Morgan
Successful Strategies for Recruiting Family Day Care Providers/Review of
Vol. 7, No. 5, June 1987, p.34

Davis, John A.
Two Principles to Govern Judgment
Vol. 7, No. 5, June 1987, p.26

Dittmann, Laura L.
Finding the Best Care for Your Infant or Toddler/Review of
Vol. 6, No. 2, December 1985, p.17

Dombro, A.L. and Bryan, P.
Sharing the Caring: How To Find the Right Child Care and Make It Work for You and Your Child/Review of
Vol. 12, No. 1, September 1991, p.32

Fallows, Deborah
A Mother's Work/Review of
Vol. 6, No. 3, February 1986, p.14

Fernandez, John P.
Child Care and Corporate Productivity/Review of
Vol. 7, No. 1, September 1986, p.18

Finn-Stevenson, Matia and Ward, Pat
Outreach to Family Day Care: A National Volunteer Initiative
Vol. 10, No. 3, February 1990, p.18

Fitzcharles, Alice
Model Versus Modal Child Care (Comment)
Vol. 7, No. 3, February 1987, p.26

Foote, BA
Managing Growth at Child Care Solutions
Vol. 11, No. 4, April 1991, p.27

Fredericks, Beth; Hardman, Robin; Morgan, Gwen and Rodgers, Fran
A Little Bit under the Weather: A Look at Care for Mildly Ill Children/Review of
Vol. 7, No. 5, June 1987, p.34

Friedman, Dana, for Carnegie Corporation of New York
Encouraging Employer Support to Working Parents: Community Strategies for Change/Review of
Vol. 3, No. 4, July 1983, p.14

Friedman, Dana
Corporate Financial Assistance for Child Care/Review of
Vol. 6, No. 3, February 1986, p.13

Friedman, Sarah. L.
NICHD Infant Child-Care Network: The National Study of Young Children's Lives
Vol. 10, No. 3, February 1990, p.21

Galinsky, Ellen
Investing in Quality Child Care: A Report for AT&T/Review of
Vol. 7, No. 3, February 1987, p.29

Gerber, Magda
Caring for Infants With Respect: The RIE Approach
Vol. 6, No. 3, February 1986, p.1

Goldstein, Stephen E., ed.
Promoting Mental Health in Early Child Care Settings: Proceedings of the Second Annual UCLA National Conference on Prevention Psychiatry/Review of
Vol. 10, No. 4, April 1990, p.24

Gonzalez-Mena, J. and Eyer, D.W.
Infants, Toddlers, and Caregivers/Review of
Vol. 11, No. 3, February 1991, p.33

Griffin, A.
State Regulations Concerning Toddlers in Child Care
Vol. 11, No. 3, February 1991, p.11

Gunzenhauser, Nina and Caldwell, Bettye M., eds.
Group Care for Young Children: Considerations for Child Care and Health Professionals, Public Policy Makers, and Parents/Review of
Vol. 7, No. 1, September 1986, p.17

Guttentag, Robert
From Another Perspective
Vol. 8, No. 2, December 1987, p.21

Harms, Thelma and Clifford, Richard
Family Day Care Rating Scale/Review of
Vol. 9, No. 5, June 1989, p.27

Heath, Harriet
A Good Reference for Parents
Vol. 7, No. 3, February 1987, p.25

Honig, Alice and Lally, J. Ronald
Infant Caregiving: A Design for Training/Review of
Vol. 2, No. 2, December 1981, p.14

Honig, Alice S. and Wittmer, Donna Sasse
Infant/Toddler Caregiving: An Annotated Guide to Media Training Materials/Review of
Vol. 10, No. 1, September 1989, p.34

Howes, Caroline
Keeping Current in Child Care Research: An Annotated Bibliography
Vol. 7, No. 1, September 1986, p.17

Jervis, Kathe, ed.
A Guide to Attachment, Separation and Loss: Strategies for Helping Two to Four Years Old/Review of
Vol. 6, No. 2, December 1985, p.17

Johnston, Kadija
Mental Health Consultation to Day Care Providers: The San Francisco Daycare Consultants Program
Vol. 10, No. 3, February 1990, p.7

BEST COPY AVAILABLE

Kahn, Alfred J. and Kamerman, Sheila B.
Child Care: Facing the Hard Choices/ Review of
Vol. 7, No. 5, June 1987, p.33

Kearney, Paul
Babyland: A Story of Caring
Vol. 6, No. 2, December 1985, p.13

Lally, J. Ronald
Some Common Concerns of Mothers Who Work Outside the Home
Vol. 1, No. 3, March 1981, p.10

Leavett, Robin Lynn and Eheart, Brenda Krause
Toddler Day Care: A Guide to Responsive Caregiving/Review of
Vol. 7, No. 1, September 1986, p.18

Lindner, Eileen; Mattis, Mary; and Rogers, June
When Churches Mind the Children: A Study of Day Care in Local Parishes/Review of
Vol. 4, No. 3, February 1984

Maryland Committee for Children
Children, Families and Child Care in Maryland/ Review of
Vol. 7, No. 5, June 1987, p.14

Miringoff, Nancy
A Timely and Controversial Article
Vol. 7, No. 3, February 1987, p.26

Morgan, Gwen
The National State of Child Care Regulation, 1986/Review of
Vol. 8, No. 4, April 1988, p.24

Muir, Elisabeth and Tuters, Elizabeth
An Infant Mental Health Training Model for Day Care Professionals: The C.M. Hincks Institute National Day Care Training Project
Vol. 10, No. 3, February 1990, p.12

Nash, Margaret and Tate, Costella
Better Baby Care: A Book for Family Day Care Providers/Review of
Vol. 7, No. 2, December 1986, p.17

Neugebauer, Roger & Lurie, Robert, eds.
Caring for Infants & Toddlers: What Works, What Doesn't/Review of
Vol. 1, No. 4, June 1981, p.12

Pawl, Jeree
Infants in Day Care: Reflections on Experience, Expectations and Relationships
Vol. 10, No. 3, February 1990, p.1

Phillips, Deborah, McCartney, Kathleen; Scarr, Sandra and Howes, Carollee
Selective Review of Infant Day Care Research: A Cause for Concern!
Vol. 7, No. 3, February 1987, p.18

Pizzo, Peggy Daly
Whole Babies, Parents and Pizzo & Funds: Creating Comprehensive Programs for Infants and Toddlers
Vol. 10, No. 3, February 1990, p.24

Platt, E.B.
Scenes from Day Care: How Teachers Teach and What Children Learn/Review of
Vol. 12, No. 4, April 1992, p.32

Program for Infant/Toddler Caregivers
Infant/Toddler Caregiving: Guides to Creating Partnerships with Families, Routines, Setting Up Environments, and Social-emotional Growth and Socialization/ Review of
Vol. 11, No. 3, February 1991, p.33

Richardson, Gail and Marx, Elizabeth
A Welcome for Every Child: How France Achieves Quality in Child Care/Review of
Vol. 10, No. 4, April 1990, p.23

Schloesser, Patricia T.
Health of Children in Day Care: Public Health Profiles/Review of
Vol. 7, No. 5, June 1987, p.33

Schrag, Emily
Infant and Toddler Care in the States: The Comparative Licensing Study and Beyond
Vol. 4, No. 3, February 1984, p.8

Select Committee on Children, Youth & Families
Improving Child Care Services: What Can Be Done?/Review of
Vol. 5, No. 5, June 1985, p.17

Siegel, Maxine
Therapeutic Child Care at Merrywood School
Vol. 7, No. 1, September 1986, p.13

Thompson, Ross
Attachment Theory and Day Care Research
Vol. 8, No. 2, December 1987, p.21

Torelli, Louis
The Developmentally Designed Group Care Setting: A Supportive Environment for Infants, Toddlers and Caregivers
Vol. 10, No. 2, December 1989, p.7

Werner, Emmy E.
Child Care: Kith, Kin and Hired Hands/ Review of
Vol. 6, No. 2, December 1985, p.17

Whitebook, Marcy; Howes, Carollee and Phillips, Deborah
Who Cares? Child Care Teachers and the Quality of Care in America/Review of
Vol. 10, No. 2, December 1989, p.27

Whitehurst, G.J. and Fischel, J.E.
Shared Reading in Daycare: Successes and Challenges
Vol. 12, No. 1, September 1991, p.15

Wittmer, D. and Petersen, S.
Social Development and Integration: Facilitating the Prosocial Development of Typical and Exceptional Infants and Toddlers in Group Settings
Vol. 12, No. 4, April 1992, p.14

Wittmer, Donna
Caring for Infants and Toddlers/Review of
Vol. 6, No. 3, February 1986, p.14

Wittmer, Donna S.
Model Versus Model: Child Care for Children from Low-Income Families
Vol. 7, No. 1, September 1986, p.8

Zigler, E.F. and Lang, M.E.
Child Care Choices: Balancing the Needs of Children, Families and Society/Review of
Vol. 11, No. 4, April 1991, p.31

Zinsser, Caroline
Born and Raised in East Urban: A Community Study of Informal and Unregulated Child Care/Review of
Vol. 10, No. 4, April 1990, p.22

Zinsser, Caroline
Day Care's Unfair Burden: How Low Wages Subsidize A Public Service/Review of
Vol. 7, No. 2, December 1986, p.17

Zinsser, Caroline
Over a Barrel: Working Mothers Talk About Child Care/Review of
Vol. 8, No. 4, April 1988, p.24

Zinsser, Caroline
Raised in East Urban: Child Care Changes in a Working Class Community/Review of
Vol. 12, No. 5, June 1992, p.60

CHILD MALTREATMENT

Breakey, G. and Pratt, B.
Healthy Growth for Heaven's "Healthy Start": Toward a Systematic Statewide Approach to the Prevention of Child Abuse and Neglect
Vol. 11, No. 4, April 1991, p.16

Cicchetti, D. and Carlson, V.
Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect/Review of
Vol. 11, No. 2, December 1990, p.25

Egeland, B. and Erickson, M.F.
Rising Above the Past: Strategies for Helping New Mothers Break the Cycle of Abuse and Neglect
Vol. 11, No. 2, December 1990, p.29

Solnit, A.J.; Nordhaus, B.F. and Lord, R.
When Home is No Haven: Child Placement Issues/Review of
Vol. 12, No. 4, April 1992, p.33

CHRONIC ILLNESS

Hobbs, Nicholas, and Perrin, James M., eds.
Issues in the Care of Children with Chronic Illness/Review of
Vol. 6, No. 4, April 1986, p.15

Hobbs, Nicholas; Perrin, James M. and Ireys, Henry T.
Chronically Ill Children and Their Families: Problems, Prospects and Proposals from the Vanderbilt Study/Review of
Vol. 6, No. 4, April 1986, p.15

DEVELOPMENT

Aronfeld, Moshe
Language Development from Birth to Three/Review of
Vol. 7, No. 4, April 1987, p.23

Anthony, E. James and Pollock, George H., eds.
Parental Influences: In Health and Disease/Review of
Vol. 6, No. 5, June 1986, p.17

Anthony, E. James and Cohler, Bertram J., eds.
The Invulnerable Child/Review of
Vol. 8, No. 1, September 1987, p.26

Barnard, K.E. and Brazelton, T.B., eds.
Touch: The Foundation of Experience—Clinical Infant Reports #4/Review of
Vol. 11, No. 1, September 1990, p.28

Burns, Beverly
The Mother-Infant Tie: Fifty Years of Theory, Science and Science Fiction/Review of
Vol. 6, No. 3, February 1986, p.14

Bloom, Kathleen, ed.
Prospective Issues in Infancy Research/Review of
Vol. 3, No. 2, December 1982, p.5

Bloom, L.
Language Development from Two to Three/Review of
Vol. 12, No. 1, September 1991, p.31

Bornstein, Marc and Lamb, Michael, eds.
Developmental Psychology: An Advanced Textbook/Review of
Vol. 3, No. 3, February 1983, p.23

Bowlby, John
A Secure Base: Parent-Child Attachment and Healthy Human Development/Review of
Vol. 10, No. 1, September 1989, p.35

Brazelton, T. Berry and Yogman, Michael, eds.
Affective Development in Infancy/Review of
Vol. 6, No. 3, June 1986, p.18

Brazelton, T. Berry
Assessment As a Method For Enhancing Infant Development
Vol. 2, No. 1, September 1981, p.1

Bretherton, Inge and Waters, Everett, eds.
Growing Points of Attachment Theory and Research/Review of
Vol. 7, No. 5, June 1987, p.31

Brosman, Sarah; Biren, Ellen and Shaughnessy, Peter
Late Achieving Children: The First Seven Years/Review of
Vol. 7, No. 2, December 1986, p.16

Brown, Catherine Caldwell and Gottfried, Allen, eds.
Play Interactions: The Role of Toys and Parental Involvement in Children's Development/Review of
Vol. 5, No. 5, June 1985, p.19

Brown, Catherine Caldwell, ed.
The Many Facets of Touch/Review of
Vol. 5, No. 1, September 1984, p.6

Buss, Arnold and Plomin, Robert
Temperament: Early Developing Personality Traits/Review of
Vol. 5, No. 3, February 1985, p.25

Chasnoff, Ira J., ed.
Drug Use in Pregnancy: Mother and Child/Review of
Vol. 7, No. 2, December 1986, p.17

Chess, Stella and Thomas, Alexander
Origins and Evolution of Behavior Disorders from Infancy and Early Adult Life/Review of
Vol. 5, No. 3, February 1985, p.25

Children Today
The Earliest Years (July/Aug. 91)/Review of
Vol. 2, No. 1, September 1986, p.14

Cox, M.V.
The Child's Point of View (second edition)/Review of
Vol. 12, No. 4, April 1992, p.33

Damon, William, ed.
Child Development Today and Tomorrow/Review of
Vol. 9, No. 5, June 1989, p.

Dombro, Amy Laura and Wallach, Leah
The Ordinary Is Extraordinary: How Children under Three Learn/Review of
Vol. 9, No. 1, September 1988, p.29

Eisenberg, N.
The Caring Child/Review of
Vol. 12, No. 4, April 1992, p.30

Emde, Robert N. and Harmon, Robert J., eds.
Continuities and Discontinuities in Development/Review of
Vol. 6, No. 1, September 1985, p.16

Emde, Robert, ed.
Rene A. Spitz: Dialogues from Infancy/Review of
Vol. 4, No. 3, June 1984, p.13

Escalona, Sibylle K.
Critical Issues in the Early Development of Premature Infants/Review of
Vol. 9, No. 2, December 1988, p.22

Farran, Dale C. and McKinney, James D., eds.
Risk in Intellectual and Psychosocial Development/Review of
Vol. 7, No. 4, April 1987, p.22

Feagans, Lynne and Farran, Dale Clark, eds.
The Language of Children Reared in Poverty: Implications for Evaluation and Intervention/Review of
Vol. 5, No. 2, December 1984, p.12

Field, Tiffany and Sostek, Anita, eds.
Infants Born At Risk: Physiological, Perceptual and Cognitive Processes/Review of
Vol. 4, No. 2, December 1983, p.15

Field, Tiffany M.; McCabe, Philip N. and Schneiderman, Neil, eds.
Stress and Coping Across Development/Review of
Vol. 9, No. 5, June 1989, p.27

Fogel, Alan and Melson, Gail
Origins of Nurturance: Development, Biological and Cultural Perspectives on Caregiving/Review of
Vol. 6, No. 5, June 1986, p.18

Fowler, W.
Talking from Infancy: How to Nurture and Cultivate Early Language Development/Review of
Vol. 12, No. 1, September 1991, p.31

Furman, E.
Toddlers and Their Mothers: A Study in Early Personality Development/Review of
Vol. 12, No. 5, June 1992, p.41

Gallagher, James and Ramey, Craig, eds.
The Malleability of Children/Review of
Vol. 8, No. 1, September 1987, p.26

Gilligan, Carol
The Origins of Morality in Early Childhood/Review of
Vol. 8, No. 4, April 1988, p.25

Goldberger, Joy
Infants and Toddlers in Hospitals: Addressing Developmental Risks
Vol. 8, No. 3, February 1988, p.1

Greenspan, Stanley
Intelligence and Adaptation: An Integration of Psychoanalysis and Piagetian Developmental Psychology/Review of
Vol. 1, No. 2, December 1980, p.12

Greenspan, Stanley I.
Clinical Developmental Approaches to Infants & Their Families
Vol. 1, No. 1, September 1980, p.3

Greenspan, Stanley
Twelve to Eighteen Months: The Stage of The Second Year
Vol. 2, No. 2, December 1981, p.1.

Greenspan, Stanley and Greenspan, Nancy Thorndike
First Feelings: Milestones in the Emotional Development of Your Baby & Child from Birth to Age 4/Review of
Vol. 5, No. 4, April 1984, p.21

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Infants in Multirisk Families: Case Studies in Preventive Intervention/Review of
Vol. 7, No. 4, April 1987, p.19

Gunzenhauser, N., ed.
Advances in Touch: New Implications in Human Development/Review of
Vol. 11, No. 1, September 1990, p.28

Hanson, Marci J., ed.
Atypical Infant Development/Review of
Vol. 6, No. 1, September 1985, p.15

Harel, Shaul and Anastasiow, Nicholas, eds.
The At-Risk Infant: Psycho/Socio/Medical Aspects/Review of
Vol. 1, No. 5, p.18

Harris, Robie
Interview with Robie Harris
Vol. 1, No. 3, March, 1981, p.F

Honig, Alice Sterling, ed.
Risk Factors in Infancy/Review of
Vol. 7, No. 4, April 1987, p.22

Horowitz, Frances D.
Making a Model of Development and Its Implications for Working with Young Infants
Vol. 6, No. 2, December 1985, p.1

Horowitz, F.D. and Columbo, J., eds.
Infancy Research: A Summative Evaluation and a Look to the Future/Review of
Vol. 11, No. 1, September 1990, p.30

Howes, C. with Unger, O. and Matheson, C.C.
The Collaborative Construction of Pretend: Social Pretend Play Functions/Review of
Vol. 12, No. 4, April 1992, p.32

Isseri, Carroll, Kagan, Jerome; and Zax, Melvin, Robert, eds.
Emotion, Cognition and Behavior/Review of
Vol. 5, No. 1, September 1984, p.14

Kagan, Jerome
The Nature of the Child/Review of
Vol. 5, No. 3, February 1985, p.26

Kagan, Jerome
The Second Year of Life: The Emergence of Self-Awareness/Review of
Vol. 3, No. 2, December 1982, p.5

Kagan, Jerome
Unstable Ideas: Temperament, Cognition and Self/Review of
Vol. 9, No. 5, June 1989, p.27

Kagan, Jerome and Greenspan, Stanley
Milestones in Development: A Dialogue
Vol. 6, No. 5, June 1986, p.1

Kay, Kenneth
The Mental and Social Life of Babies: How Parents Create Persons/Review of
Vol. 3, No. 4, July 1983, p.14

Klaus, Marshall H. and Phyllis H.
The Amazing Newborn: Making the Most of the First Weeks of Life/Review of
Vol. 6, No. 4, April 1986, p.15

Klaus, Marshall and Robertson, Martha Ouchen, eds.
Birth, Interaction, and Attachment: Stepping The Foundation for Modern Perinatal Care/Review of
Vol. 3, No. 2, December 1982, p.5

Korner, Anneliese F.
Infant Stimulation: The Pros and Cons in Historical Perspective
Vol. 10, No. 2, December 1989, p.11

Korner, Anneliese
Interconnections Between Sensory and Affective Development in Early Infancy
Vol. 5, No. 1, September 1984, p.1

Lerner, Jacqueline V. and Lerner, Richard M.
Temperament and Social Interaction in Infants and Children/Review of
Vol. 7, No. 3, February 1987, p.28

Lester, Barry M. and Boukydis, C.V. Zachariah, eds.
Infant Crying: Theoretical and Research Perspectives/Review of
Vol. 6, No. 1, September 1985, p.16

Lewis, M.
Shame: The Exposed Self
Vol. 12, No. 4, April 1992, p.6

Lewis, M.
Shame: The Exposed Self/Review of
Vol. 12, No. 4, April 1992, p.30

Lewis, M. and Feinman, S., eds.
Social Influences and Socialization in Infancy/Review of
Vol. 12, No. 4, April 1992, p.30

Lewis, Michael, ed.
Beyond the Dyad/Review of
Vol. 6, No. 3, February 1986, p.14

Lewis, Michael and Michalson, Linda
Children's Emotions and Moods: Developmental Theory and Measurement/Review of
Vol. 4, No. 4, April 1984, p.17

Lieberman, A.F.
Attachment and Exploration: The Toddler's Dilemma
Vol. 11, No. 3, February 1991, p.6

Lipsitt, Lewis, ed.
Advances in Infancy Research: Monographs in Infancy/Review of
Vol. 2, No. 4, June 1982, p.12

Lipsitt, Lewis P.
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Vol. 1, No. 2, December 1980, p.12

Lipsitt, Lewis and Field, Tiffany, eds.
Infant Behavior and Development: Perinatal Risk and Newborn Behavior/Review of
Vol. 3, No. 4, July 1983, p.13

Lipsitt, Lewis P., ed.
The Brown University Human Development Letter/Review of
Vol. 6, No. 2, December 1985, p.16

Mack, John and Ablon, Steven, eds.
The Development and Sustaining of Self-Esteem in Childhood
Vol. 5, No. 1, September 1984, p.14

Marcus, Joseph and Aubrey, Anne
Multidimensional Statistical Analysis: A Partner for Clinical Insight
Vol. 3, No. 1, October 1982, p.1

McLane, J.B. and McNamee, G.D.
The Beginnings of Literacy
Vol. 12, No. 1, September 1991, p.1

McLane, J.B. and McNamee, G.D.
Early Literacy/Review of
Vol. 12, No. 1, September 1991, p.31

McLean, L.K.S.
Communication Development in the First Two Years of Life: A Transactional Process
Vol. 11, No. 1, September 1990, p.13

Meissner, C.E.
What's It Mean To Share a Story?
Vol. 12, No. 1, September 1991, p.10

Murphy, L.B.
Sympathetic Behavior in Very Young Children
Vol. 12, No. 4, April 1992, p.1

Murphy, L.B. and Small, C.
Toddlers: Themes and Variations
Vol. 11, No. 3, February 1991, p.1

49

Murphy, Lois Barclay
Coping in Infants and Toddlers
Vol. 4, No. 4, April 1984, p.11

Murphy, Lois Barclay and Small, Colleen T.
The Baby's World
Vol. 10, No. 2, December 1989, p.1

Murphy, Lois Barclay; Hesser, Grace M. and Small, Colleen
Individual Differences in Infants
Vol. 7, No. 2, December 1986, p.1

Musick, Judith and Weissbourd, Bernice, eds.
Infants: Their Social Environments/Review of
Vol. 2, No. 1, September 1981, p.14

Norton, Dolores G.
Understanding the Early Experience of Black Children in High Risk Environments: Culturally and Ecologically Relevant Research as a Guide to Support for Families
Vol. 10, No. 4, April 1990, p.1

Nugent, J. Kevin; Lester, Barry M. and Brazelton, T. Berry
The Cultural Context of Infancy, Volume I: Biology, Culture, and Infant Development/Review of
Vol. 10, No. 4, April 1990, p.22

Osofsky, Joy. D., ed.
Handbook of Infant Development, Second Edition/Review of
Vol. 7, No. 5, June 1987, p.31

Parkes, Colin, Murray and Stevenson-Hinde, Joan, eds.
The Place of Attachment in Human Behavior/Review of
Vol. 3, No. 2, December 1982, p.5

Pawl, J.H.
A Book Is a Child's Companion
Vol. 12, No. 1, September 1991, p.9

Plomin, Robert and Dunn, Judith, eds.
The Study of Temperament: Changes, Continuities and Challenges
Vol. 6, No. 5, June 1986 p.17

Plomin, Robert; Defries, John C. and Fulker, David W.
Nature and Nurture during Infancy and Early Childhood/Review of
Vol. 9, No. 2, December 1988 p.25

Polymorph Films
The Sensational Baby: Newborn Sensory Development/Review of
Vol. 5, No. 2, December 1984, p.13

Press, Billie and Greenspan, Stanley
The Toddler Group: A Setting for Adaptive Social-Emotional Development of Disadvantaged One and Two Year Olds in a Peer Group
Vol. 5, No. 4, April 1985, p.6

Pruzant, B.M., and Wetherby, A.M.
Assessing the Communication of Infants and Toddlers: Integrating a Sociocultural Perspective
Vol. 11, No. 1, September 1990, p.1

Pruthansky, Harold M. and Gottlieb, Nina M.
The Development of Place Identity in the Child
Vol. 10, No. 2, December 1989, p.18

Rovee-Collier, Carolyn and Lipsitt, Lewis P., eds.
Advances in Infancy Research, Volume 5/Review of
Vol. 9, No. 2, December 1988, p.25

Rutter, Michael, ed.
Studies of Psychosocial Risk: The Power of Longitudinal Data/Review of
Vol. 10, No. 2, December 1989, p.27

Schaefelbusch, Richard and Bricker, Diane, eds.
Early Language: Acquisition and Intervention/Review of
Vol. 3, No. 4, July 1983, p.13

Segal, Marylin
Birth to One Year/Review of
Vol. 4, No. 5, June 1984, p.14

Segal, Marilyn and Adcock, Dan
Your Child at Play—Birth to One Year, One to Two Years, Two to Three Years/Review of
Vol. 6, No. 1, September 1985, p.16

Shapiro, Edna and Weber, Evelyn, eds.
Cognitive and Affective Growth: Developmental Interaction/Review of
Vol. 3, No. 2, December 1982, p.11

Singer, D.G. and Singer, J.L.
The House of Make-Believe: Play and the Developing Imagination/Review of
Vol. 12, No. 4, April 1992, p.32

Smeriglio, V.L., ed.
Newborns and Parents: Parent-Infant Contact and Newborn Sensory Stimulation/Review of
Vol. 2, No. 1, September 1981, p.14

Spencer, Margaret B., Brookins, Geraldine K. and Allen, Walter R., eds.
Beginnings: The Social and Affective Development of Black Children/Review of
Vol. 7, No. 2, December 1986, p.16

Stern, D.N.
Diary of a Baby: What Your Child Sees, Feels and Experiences/Review of
Vol. 11, No. 2, December 1990, p.42

Stern, Daniel N.
The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology/Review of
Vol. 6, No. 2, December 1985, p.16

Super, Charles M., ed.
The Role of Culture in Developmental Disorder/Review of
Vol. 9, No. 2, December 1988, p.25

Tamir, Dov, Brazelton, T. Berry and Russell, Alex, eds.
Stimulation and Intervention in Infant Development: Theories, Evaluation and Research, Programs in the Community, Fetal Behavior and Intervention for the Child at Risk/Review of
Vol. 7, No. 2, December 1986, p.16

Thoman, Evelyn B. and Browder, Sue
Born Dancing: How Intuitive Parents Understand Their Baby's Unspoken Language and Natural Rhythms/Review of
Vol. 7, No. 5, June 1987, p.32

Thompson, Ross A., ed.
Socioemotional Development: Nebraska Symposium on Motivation, 1988/Review of
Vol. 10, No. 5, June 1990, p.

Tronick, Edward Z.
Interactive Mismatch and Repair: Challenges to the Coping Infant
Vol. 6, No. 3, February 1986, p.1

Verdonik, Frederic, and Sherrod, Lonnie J.
An Inventory of Longitudinal Research on Childhood and Adolescence/Review of
Vol. 6, No. 4, April 1986, p.16

Wachs, Theodore, and Gruen, Gerald
Early Experience and Human Development/Review of
Vol. 4, No. 4, April 1984, p.16

Wallerstein, N.
Observations of an Active Toddler
Vol. 11, No. 3, April 1991, p.5

Weinstein, Carol Simon and David, Thomas G., eds.
Spaces for Children: The Built Environment and Child Development/Review of
Vol. 9, No. 2, December 1988, p.24

Werner, Emmy
Individual Differences, Universal Needs: A 30-year Study of Resilient High-Risk Infants
Vol. 8, No. 4, April 1988, p.1

Wilberger, Patricia
Planning an Adequate "Sensory Diet": Application of Sensory Processing Theory During the First Year of Life
Vol. 5, No. 1, September 1984, p.9

Williamson, G. Gordon
Motor Control as a Resource for Adaptive Coping
Vol. 9, No. 1, September 1988, p.1

Winnicott, D.W.
Babies and Their Mothers/Review of
Vol. 7, No. 5, June 1987, p.32

Wispe, L.
The Psychology of Sympathy/Review of
Vol. 12, No. 4, April 1992, p.31

Woolston, J.L.
Eating and Growth Disorders in Infants and Children/Review of
Vol. 12, No. 5, June 1992, p.38

Yarrow, Leon
Beyond Cognition: The Development of Mastery Motivation
Vol. 1, No. 3, March 1981, p.1

Zigler, Edward and Finn-Stevenson, Matia
Children: Development and Social Issues/Review of
Vol. 8, No. 1, September 1987, p.26

Zigler, Edward and Lang, Mary
The "Gourmet Baby" and the "Little Wildflower"
Vol. 7, No. 2, December 1986, p.6

DISABILITIES

Ala, Hendrikse
Reciprocity and Autonomy: Parenting a Blind Infant
Vol. 5, No. 5, June 1985, p.8

Anderson, Penny P. and Fenichel, Emily Schrag
Serving Culturally Diverse Families of Infants and Toddlers with Disabilities/Review of
Vol. 10, No. 2, December 1989, p.27

Association for the Care of Children's Health
Home Care for Children with Handicapping Conditions/Review of
Vol. 5, No. 4, April 1985, p.21

Batshaw, Mark and Perret, Yvonne
Children With Handicaps: A Medical Review/Review of
Vol. 2, No. 4, June 1982, p.12

Bennett, T., Raab, M. and Nielsen, D.
The Transition Process for Toddlers with Special Needs and Their Families
Vol. 11, No. 3, February 1991, p.17

Berman, Carol, Bess, Patricia, and Fenichel, Emily Schrag, eds.
Keeping Track: Tracking Systems for High Risk Infants and Young Children, Second Edition/Review of
Vol. 10, No. 3, February 1990, p.32

Blacher, Jan, ed.
Severely Handicapped Young Children and Their Families: Research in Review
Vol. 5, No. 5, June 1985, p.18

Bricker, Diane B.
Early Intervention for At Risk and Handicapped Infants, Toddlers and Preschool Children, Second Edition/Review of
Vol. 10, No. 3, February 1990, p.32

Bricker, D. and Cripe, J.J.W.
An Activity-based Approach to Early Intervention/Review of
Vol. 12, No. 3, February 1992, p.36

Brown, Catherene Caldwell, ed.
Childhood Learning Disabilities and Prenatal Risk: An Interdisciplinary Data Review for Health Care Professionals and Parents/Review of
Vol. 4, No. 4, April 1984, p.16

Bruder, Mary Beth; Deener, Penny and Sachs, Sandy
Models of Integration Through Early Intervention/Child Care Collaborations
Vol. 10, No. 3, February 1990, p.14

Clark, Roseanne and Ottmans, Mary Jane
"The Sooner the Better Project": Involving Parents and Day Care Staff in the Identification and Treatment of Developmental Delays and Disturbances in Infants and Toddlers
Vol. 7, No. 1, September 1986, p.10

Comfort, Randy Lee
The Unconventional Child: A Book for Parents of Children with Learning Disabilities/Review of
Vol. 1, No. 4, June 1981, p.12

Coughlin, Sherri, Leviton, Audrey and Mueller, Mary
Parent Training from the Speech-Language Pathologist's Perspective: A Case Study
Vol. 9, No. 4, April 1989, p.16

Edge, Elsie and Pizzo, Peggy, eds.
Four Critical Junctures: Support for Parents of Children with Special Needs/Review of
Vol. 9, No. 4, April 1989, p.23

Ensher, Gail and Clark, David
Newborns at Risk: Medical Care and Psychoeducational Intervention/Review of
Vol. 8, No. 3, February 1988, p.28

Featherstone, Helen
A Difference in The Family: Life With A Disabled Child/Review of
Vol. 1, No. 4, June 1981, p.12

Fox, Harriette B.
Medicaid Financing for Early Intervention Services/Review of
Vol. 8, No. 5, June 1988, p.25

Frankenburg, William K; Emde, Robert N. and Sullivan, Joseph W., eds.
Early Identification of Children at Risk: An International Perspective/Review of
Vol. 7, No. 2, December 1986, p.16

Fraser, D.L.
A Nonverbal Intervention for the Severely Language Disordered Young Child: An Intensive Approach
Vol. 11, No. 1, September 1990, p.23

Gerber, Howard L.
The Milwaukee Project: Preventing Mental Retardation in Children At Risk/Review of
Vol. 10, No. 1, September 1989, p.36

Garwood, S. Gray and Fewell, Rebecca, eds.
Educating Handicapped Infants: Issues in Development and Intervention/Review of
Vol. 4, No. 1, September, 1983, p.14

Gilkerson, Linda, Hilliard, Asa Grant, Schrag, Emily and Shonkoff, Jack P.
Commenting on P.L. 99-457
Vol. 7, No. 3, February 1987, p.13

Greenspan, S.I.
An Intensive Approach to a Toddler with Emotional, Motor, and Language Delays: A Case Report
Vol. 11, No. 1, September 1990, p.20

Greenspan, Stanley I.
Fostering Emotional and Social Development in Infants with Disabilities
Vol. 9, No. 1, September 1988, p.8

Harris, Lisa Ingelfinger
The Effectiveness of a Feeding Support Group as an Adjunct to Other Therapies in an Early Intervention Program
Vol. 9, No. 4, April 1989, p.12

Hasenstab, M. Suzanne and Horner, John
Comprehensive Intervention with Hearing-Impaired Infants and Preschool Children/Review of
Vol. 4, No. 2, December 1983, p.17

Healy, Alfred, Keesee, Patricia, and Smith, Keesee, Barbara
Early Services for Children with Special Needs: Transactions for Family Support/Review of
Vol. 5, No. 5, June 1985, p.16

Hodapp, R.M., Burack, J.A. and Zigler, E., eds.
Issues in the Developmental Approach to Mental Retardation/Review of
Vol. 11, No. 3, February 1991, p.34

Johnson, Allen Frank
Developmental Achievement in the Child With Spina Bifida/Review of
Vol. 1, No. 5, June 1981, p.12

Johnson, Beverley H.; McGonigel, Mary J. and Kaufmann, Roxane, eds.
Guidelines and Recommended Practices for the Individualized Family Service Plan/Review of
Vol. 10, No. 1, September 1989, p.34

Kalmanson, Barbara and Pekarsky, Judith H.
Infant-Parent Psychotherapy with an Autistic Toddler
Vol. 7, No. 3, February 1987, p.1

Lyon, Jeff
Playing God in the Nursery/Review of
Vol. 6, No. 3, June 1986, p.18

Manes, J. and Carty, L.
SSI: New Opportunities for Children with Disabilities/Review of
Vol. 11, No. 4, April 1991, p.32

March of Dimes Birth Defects Foundation
Birth Defects: Original Article Series, Volume XVII, 1982/Review of
Vol. 2, No. 4, June 1982, p.12

McCrae, Marcia
Medical Perspectives on Brain Damage and Development/Review of
Vol. 3, No. 3, April 1983, p.14

McPherson, Merle
Improving Services to Infants and Young Children with Handicapping Conditions and Their Families: The Division of Maternal & Child Health as Collaborator
Vol. 4, No. 1, September 1983, p.1

Meisels, Samuel J. and Provence, Sally
Screening and Assessment: Guidelines for Identifying Young Disabled and Developmentally Vulnerable Children and Their Families/Review of
Vol. 10, No. 2, December 1989, p.26

Moran, Mary
Families in Early Intervention: Effects of Program Variables/Review of
Vol. 4, No. 5, June 1985, p.11

Mulick, James and Pueschel, Siegfried, eds.
Parent-Professional Partnerships in Developmental Disability Services/Review of
Vol. 4, No. 5, June 1984, p.13

National Center for Clinical Infant Programs
Equals in This Partnership: Parents of Disabled and At-Risk Infants & Toddlers Speak to Professionals/Review of
Vol. 5, No. 5, June 1985, p.16

National Center for Clinical Infant Programs
Keeping Track: Tracking Systems for High Risk Infants and Young Children/Review of
Vol. 6, No. 1, September 1985, p.15

National Information Center for Children and Youth with Handicaps
Parents' Guide to Accessing Programs for Infants, Toddlers, and Preschoolers with Handicaps and A Parent's Guide to Accessing Parent Groups, Community Services, and to Keeping Records/Review of
Vol. 10, No. 1, September 1989, p.35

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A Parent's Guide: Accessing Programs for Infants, Toddlers and Preschoolers with Disabilities/Review of
Vol. 11, No. 4, April 1991, p.32

Odom, Samuel and Karnes, Merle, eds.
Early Intervention for Infants and Children with Handicaps: An Empirical Base/Review of
Vol. 9, No. 1, September 1988, p.28

Passanisi, S.S. and DiGangi, G.A.
Emotional and Sensory Processing Problems: Assessment and Treatment Approaches for Young Children and Their Families/Review of
Vol. 12, No. 2, December 1991, p.41

Powell, Thomas and Ogle, Peggy Ahrenhold
Brothers and Sisters: A Special Part of Exceptional Families/Review of
Vol. 5, No. 5, June 1985, p.18

Ramey, Craig and Trohanis, Pascal, eds.
Finding and Educating High-Risk and Handicapped Infants/Review of
Vol. 3, No. 4, July 1983, p.13

Raver, S.A.
Strategies for Teaching At-Risk and Handicapped Infants and Toddlers: A Transdisciplinary Approach/Review of
Vol. 12, No. 3, February 1992, p.36

Scheller, Barbara
One Step at a Time/Review of
Vol. 2, No. 3, March 1982, p.14

Seligman, Milton and Darling, Rosalyn Benjamin
Ordinary Families, Special Children: A Systems Approach to Childhood Disability/Review of
Vol. 9, No. 5, June 1989, p.26

Shonkoff, J.P.
Early Intervention Research: Asking and Answering Meaningful Questions
Vol. 12, No. 3, February 1992, p.7

Siegel, Maxene
Therapeutic Child Care at Merrywood School
Vol. 7, No. 1, September 1986, p.13

Stack, Jack, ed.
The Special Infant/Review of
Vol. 4, No. 2, December 1983, p.17

Strain, Phillip S.
Parent Training with Young Autistic Children: A Report on the LEAP Model
Vol. 7, No. 3, February 1987, p.7

Tamur, Dov, Brazelton, T. Berry and Russell, Alex, eds.
Stimulation and Intervention in Infant Development: Theories, Evaluation and Research, Programs in the Community, Fetal Behavior and Intervention for the Child at Risk/Review of
Vol. 7, No. 2, December 1986, p.16

Thurman, S.K. and Widerstrom, A.H.
Infants and Young Children with Special Needs: A Developmental and Ecological Approach/Review of
Vol. 12, No. 3, February 1992, p.37

Weintraub, Frederick K., Ramirez, Bruce
Progress in the Education of the Handicapped and Analysis of P.L. 99-199/Review of
Vol. 5, No. 5, June 1985, p.17

Widerstrom, A.H.; Mowder, B.A. and Sandall, S.R.
At-Risk and Handicapped Newborns and Infants: Development, Assessment, and Intervention/Review of
Vol. 12, No. 3, February 1992, p.38

Williamson, G. Gordon, ed.
Children with Spina Bifida: Early Intervention and Preschool Programming/Review of
Vol. 7, No. 4, April 1987, p.23

Zigler, Edward and Balla, David, eds.
Mental Retardation: The Developmental Difference Controversy/Review of
Vol. 5, No. 2, December 1984, p.12

Zigler, Edward and Hodapp, Robert
Understanding Mental Retardation/Review of
Vol. 7, No. 2, December 1986, p.16

DRUG-EXPOSED INFANTS

Chasnoff, Ira J., ed.
Drugs, Alcohol, Pregnancy and Parenting/Review of
Vol. 9, No. 2, December 1988, p.24

Howard, Judy; Beckwith, Leda; Rodning, Carol and Kropenske, Vicki
The Development of Young Children of Substance-abusing Parents: Insights from Seven Years of Intervention and Research
Vol. 9, No. 3, June 1989, p.8

Miller, George
Addicted Infants and Their Mothers
Vol. 9, No. 3, June 1989, p.20

Tittle, Barbara and St. Claire, Nika
Promoting the Health and Development of Drug-exposed Infants through a Comprehensive Clinic Model
Vol. 9, No. 3, June 1989, p.18

Weston, Donna R.; Ivins, Barbara; Zuckerman, Barry; Jones, Coryl and Lopez, Richard
Drug-exposed Babies: Research and Clinical Issues
Vol. 9, No. 3, June 1989, p.1

Woodruff, Geneva; Sterzin, Elaine Durkot and Hanson, Christopher
Serving Drug-involved Families with HIV Infection in the Community: A Case Report
Vol. 9, No. 5, June 1989, p.12

FAILURE TO THRIVE

Brams, Jolie and Coury, Daniel
Exploring Some "Myths" of Failure to Thrive: a Brief Guide for Diagnosis and Management
Vol. 5, No. 3, February 1985, p.21

Chatoor, Irene et al.
A Developmental Approach to Feeding Disturbances: Failure to Thrive and Growth Disorders in Infants and Young Children
Vol. 5, No. 3, February 1985, p.12

Dawson, P.
Should the Field of Early Child and Family Intervention Address Failure To Thrive?
Vol. 12, No. 5, June 1992, p.20

Drotar, Dennis, ed.
New Directions in Failure to Thrive: Implications for Research and Practice/ Review of
Vol. 6, No. 5, June 1986, p.17

Drotar, Dennis
Research and Practice in Failure to Thrive: The State of the Art
Vol. 5, No. 3, February 1985, p.1

Drotar, Dennis and Malone, Charles
From Hospital to Home: Preventive Intervention with the Families of Failure to Thrive Infants
Vol. 5, No. 3, February 1985, p.17

Frank, Deborah; Allen, Deborah; and Brown, J. Larry
Primary Prevention of Failure to Thrive: Social Policy Implications
Vol. 5, No. 3, February 1985, p.4

Haynes-Seman, Claire and Hart, Joan Suzuki
Doll Play of Failure to Thrive Toddlers: Clues to Infant Experience
Vol. 7, No. 4, April 1987, p.10

Sturm, L. and Drotar, D.
Communication Strategies for Working with Parents of Infants Who Fail to Thrive
Vol. 12, No. 5, June 1992, p.25

FAMILIES

Axel, Helen
Corporations and Families: Changing Practices and Perspectives/Review of
Vol. 6, No. 3, February 1986, p.14

Blacher, Jan, ed.
Severely Handicapped Young Children and Their Families: Research in Review/ Review of
Vol. 5, No. 5, June 1985, p.18

Blankenhorn, D., Bayme, S. and Elshtain, J.B., eds.
Rebuilding the Nest: A New Commitment to the American Family/Review of
Vol. 12, No. 1, September 1991, p.32

Boudouris, James
Prisons and Kids: Program for Inmate Parents/Review of
Vol. 6, No. 3, February 1986, p.14

Boyd-Franklin, Nancy
Black Families in Therapy: A Multisystems Approach/Review of
Vol. 10, No. 4, April 1990, p.23

Brazelton, T. Berry
Families: Crisis and Caring/Review of
Vol. 10, No. 1, September 1989, p.35

Brazelton, T. Berry
On Becoming a Family/Review of
Vol. 1, No. 3, March 1981, p.15

Brazelton, T. Berry
To Listen to a Child: Understanding the Normal Problems of Growing Up/Review of
Vol. 5, No. 2, December 1984, p.13

Brazelton, T. Berry and Cramer, Bertrand G.
The Earliest Relationship: Parents, Infants and the Drama of Early Attachment/ Review of
Vol. 10, No. 3, February 1990, p.31

Bureau of National Affairs
Work and Family: A Changing Dynamic/ Review of
Vol. 7, No. 1, September 1986, p.18

Bush Center for Child Development and Social Policy at Yale University
Programs to Strengthen Families: A Resource Guide/Review of
Vol. 4, No. 2, December 1983, p.16

Catalyst
Report on a National Study of Parental Leaves/Review of
Vol. 7, No. 1, September 1986, p.18

Cochran, M.; Larner, M.; Riley, D.; Gunnarsson, L. and Henderson, C.R.
Extending Families: The Social Networks of Parents and Their Children/Review of
Vol. 12, No. 2, December 1991, p.42

Dawson, Peter; Robinson, JoAnn; and Johnson, Caroline
Informal Social Support as an Intervention
Vol. 3, No. 2, December 1982, p.1

Dornbusch, Sanford M. and Strober, Myra H., eds.
Feminism, Children and the New Families/ Review of
Vol. 9, No. 4, April 1989, p.23

Dunn, J. and Plomin, R.
Separate Lives: Why Siblings Are So Different/Review of
Vol. 11, No. 4, April 1991, p.33

Dunn, Judy and Kendrick, Carol
Siblings: Love, Envy and Understanding/ Review of
Vol. 5, No. 2, December 1984, p.13

Family Policy Panel, Economic Policy Council of the United Nations Association of the USA
Work and Family Life in the United States: A Policy Initiative/Review of
Vol. 7, No. 1, September 1986, p.18

Family Resource Coalition
Family Resource Coalition 1982 Program Directory/Review of
Vol. 3, No. 2, December 1982, p.11

Featherstone, Helen
A Difference in The Family: Life With A Disabled Child/Review of
Vol. 1, No. 4, June 1981, p.12

Gartner, A.; Kerzner, D.; Lipsky and Turnbull, A.P.
Supporting Families with a Child with a Disability: An International Outlook/ Review of
Vol. 12, No. 3, February 1992, p.36

Healy, Alfred; Keesee, Patricia; and Smith, Barbara
Early Services for Children with Special Needs: Transactions for Family Support/ Review of
Vol. 5, No. 5, June 1985, p.16

Hewlett, Sylvia Ann
A Lesser Life: The Myth of Women's Liberation in America/Review of
Vol. 7, No. 1, September 1986, p.18

Hinde, R.A. and Stevenson-Hinde, J., eds.
Relationships within Families: Mutual Influences/Review of
Vol. 11, No. 2, December 1990, p.28

Johnson, Beverley H.; McGonigel, Mary J. and Kaufmann, Roxane, eds.
Guidelines and Recommended Practices for the Individualized Family Service Plan/ Review of
Vol. 10, No. 1, September 1989, p.34

Johnson, Clifford M.; Sum, Andrew M. and Weill, James D.
Vanishing Dreams: The Growing Economic Plight of America's Young Families/ Review of
Vol. 10, No. 2, December 1989, p.30

Kagan, Sharon; Powell, Douglas and Weissbourd, Bernice, eds.
America's Family Support Programs/Review of
Vol. 8, No. 4, April 1988, p.23

Kamerman, Sheila B.; Kahn, Alfred J.; Kingston, Paul
Maternity Policies and Working Women
Vol. 6, No. 4, April 1986, p.16

Lamb, Michael, ed.
Nontraditional Families: Parenting and Child Development/Review of
Vol. 3, No. 2, December 1982, p.11

Landers, Ann
Ann Landers Writes About Infants, Parents, and Professionals
Vol. 2, No. 4, June 1982, p.9

Laosa, Luis and Sigel, Irving, eds.
Families as Learning Environments for Children/Review of
Vol. 3, No. 3, April 1983, p.12

Masenter, Sonya Gonzalez
Case Report: "It's Like Being Given a New Baby"
Vol. 3, No. 2, December 1982, p.12

Norton, Dolores G.
Understanding the Early Experience of Black Children in High Risk Environments: Culturally and Ecologically Relevant Research as a Guide to Support for Families
Vol. 10, No. 4, April 1990, p.1

Powell, D.R.
Families and Early Childhood Programs/Review of
Vol. 11, No. 1, September 1990, p.29

Powell, Thomas and Ogle, Peggy Ahrenhold
Brothers and Sisters: A Special Part of Exceptional Families/Review of
Vol. 5, No. 5, June 1985, p.18

Robertson, James & Joyce
A Baby in The Family: Living and Being Loved/Review of
Vol. 4, No. 2, December 1983, p.16

Sidel, Ruth
Women and Children Last: The Plight of Poor Women in Affluent America/Review of
Vol. 7, No. 1, September 1986, p.18

Unger, D.G. and Powell, D.G., eds.
Families as Nurturing Systems: Support Across the Life Span/Review of
Vol. 11, No. 4, April 1991, p.32

Washington, Valora and LaPoint, Velma
Black Children and American Institutions: An Ecological Review and Resource Guide/Review of
Vol. 9, No. 4, April 1989, p.22

Weissbourd, Bernice
The Family Support Movement: Greater than the Sum of Its Parts
Vol. 4, No. 1, September 1983, p.8

Yogman, Michael W. and Brazelton, T. Berry
In Support of Families/Review of
Vol. 7, No. 5, June 1987, p.31

FUNDING

Finn, Matia
Fundraising for Early Childhood Program/Review of
Vol. 3, No. 3, April 1983, p.13

Hammond, Susan; Berman, Carol; Schrag, Emily
Federal Funding for Birth to Three Programs
Vol. 6, No. 1, September 1985

HEALTH CARE

American Academy of Pediatrics
The Promotion of Breast Feeding/Review of
Vol. 2, No. 4, June 1982, p.12

American Academy of Pediatrics and American College of Obstetricians and Gynecologists
Guidelines for Perinatal Care/Review of
Vol. 4, No. 4, April 1984, p.16

American Academy of Pediatrics and American Society of Anesthesiologists
Statement on Neonatal Anesthesia
Vol. 9, No. 2, December 1988, p.5

Athey, J.L. and Kavanagh, L.
Childhood Burns: The Preventable Epidemic
Vol. 11, No. 5, June 1991, p.8

Beckett, Julie
Health Care Financing: A Guide for Families/Review of
Vol. 10, No. 1, September 1989, p.34

Brown, S.S., ed.
Children and Parental Illicit Drug Use: Research, Clinical, and Policy Issues/Review of
Vol. 11, No. 4, April 1991, p.33

Brown, Sarah S., ed.
Prenatal Care: Reaching Mothers, Reaching Infants/Review of
Vol. 9, No. 2, December 1988, p.23

Burke, Susan H. and Share, Joan
The Family Room
Vol. 7, No. 2, December 1986, p.12

Bush Institute for Child & Family Policy
Background Papers on State Action to Improve Child Health/Review of
Vol. 3, No. 3, April 1983, p.14

Campos, Rosemary Gates
Comfort Measures for Infant Pain
Vol. 9, No. 2, December 1988, p.6

Corner, Ira and Adler, Fran
Struggle To Be Born/Review of
Vol. 8, No. 5, June 1988, p.25

Editors
Frontier Nursing Service: A Demonstration in Family-Centered Primary Health Care
Vol. 4, No. 5, June 1984, p.9

Florini, K.L.; Krumbhaar, G.D., and Silbergeld, E.K.
Legacy of Lead: America's Continuing Epidemic of Childhood Lead Poisoning/Review of
Vol. 11, No. 5, June 1991, p.27

Frigoletto, Frederic and Little, George A.
Guidelines for Perinatal Care/Review of
Vol. 9, No. 2, December 1988, p.23

Gottfried, Allen and Gaiter, Juarlyn, eds.
Infant Stress Under Intensive Care: Environmental Neonatology/Review of
Vol. 5, No. 4, April 1985, p.20

Greenberg, J.
Environmental Risks to the Infants and Toddlers of Migrant Farmworkers
Vol. 11, No. 5, June 1991, p.22

Greenspan, N.T.
Infants, Toddlers, and Indoor Air Pollution
Vol. 11, No. 5, June 1991, p.14

Haskins, Ron, ed.
Child Health Policy in an Age of Fiscal Austerity: Critiques of the Select Panel Report/Review of
Vol. 2, No. 4, June, 1982, p.12

Health Focus Group of NEC*TAS
Promoting Health through Part H/Review of
Vol. 11, No. 5, June 1991, p.28

Howell, David M.
Managing Pain in Young Children: A Pediatrician's Perspective
Vol. 9, No. 2, December 1988, p.13

Hughes, Dana; Johnson, Kay; Rosenbaum, Sara; Butler, Elizabeth and Simons, Janet
The Health of America's Children: Maternal and Child Health Data Book/Review of
Vol. 8, No. 4, April 1988, p.23

Intermountain Newborn Intensive Care Center at the University of Utah
Parent-to-Parent/Review of
Vol. 4, No. 2, December 1983, p.15

Lawson, Jill R.
Standards of Practice and the Pain of Premature Infants
Vol. 9, No. 2, December 1988, p.1

Lazarus, Wendy
Back to Basics: Improving the Health of California's Next Generation/Review of
Vol. 7, No. 5, June 1987, p.32

Miller, C. Arden
Maternal Health and Infant Survival/Review of
Vol. 8, No. 1, September 1987, p.21

Miller, C. Arden; Fine, Amy; Adams-Taylor, Sharon; Schorr, Lisbeth, B.
Monitoring Children's Health: Key Indicators/Review of
Vol. 6, No. 4, April 1986, p.14

BEST COPY AVAILABLE

National Center for Education in Maternal and Child Health
Starting Early: A Guide to Federal Resources in Maternal and Child Health/Review of
Vol. 8, No. 5, June 1988, p.27

Office of Technology Assessment, U.S. Congress
Healthy Children: Investing in the Future/ Review of
Vol. 8, No. 4, April 1988, p.23

Perlman, Nitza B.
What Are They Doing to My Baby Now?
Vol. 6, No. 4, April 1986, p.11

Provence, Sally
Case Report: A Situation and Some Questions
Vol. 1, No. 3, March 1981, p.11

Rude, C.S. and Schonfeld, D.
Research in Process: A Comparison of Lead Screening Methods in Young Children
Vol. 11, No. 5, June 1991, p.7

Schloesser, Patricia T.
Health of Children in Day Care: Public Health Portion/Review of
Vol. 7, No. 5, June 1987, p.33

Select Committee on Children, Youth and Families
Environmental Toxins and Children: Exploring the Risks, Parts I and II/ Review of
Vol. 11, No. 5, June 1991, p.27

Shelov, S.P., ed.
Caring for Your Baby and Young Child Birth to Age 5: The Complete and Authoritative Guide/Review of
Vol. 12, No. 1, September 1991, p.32

Shelton, Terri, Jeppson, Elizabeth and Johnson, Beverly
Family-Centered Care for Children with Special Health Care Needs/Review of
Vol. 8, No. 1, September 1987, p.27

Surgeon General's Workshop
Children with HIV Infection and Their Families/Review of
Vol. 8, No. 1, September 1987, p.27

Thornton, Swan and Frankenburg, William, eds.
Child Health Communications: Enhancing Interactions Among Professionals, Parents, and Children/Review of
Vol. 4, No. 1, September 1983, p.13

U.S. Departments of Agriculture and Health Services
Substance Abuse During Pregnancy and Breastfeeding and Human Lactation/ Review of
Vol. 4, No. 4, April 1984, p.17

U.S. Surgeon General
Children with Special Health Care Needs Campaign 87/Review of
Vol. 8, No. 1, September 1987, p.27

Wallace, Helen, M., Ryan, George M. and Oglesby, Allan C., eds.
Maternal and Child Health Practices/ Review of
Vol. 9, No. 2, December 1988, p.25

Williams, B.C. and Miller, C.A.
Preventive Health Care for Young Children: Findings from a 10 Country Study and Directions for United States Policy/ Review of
Vol. 11, No. 5, June 1991, p.28

LOW BIRTH WEIGHT

Fleischman, Alan R.
The Immediate Impact of the Birth of a Low Birth Weight Infant on the Family
Vol. 6, No. 4, April 1986, p.1

McCarton, Cecelia
The Long-Term Impact of a Low Birth Weight Infant on the Family
Vol. 6, No. 4, April 1986, p.6

MENTAL HEALTH

Belsky, Jay and Nezworski, Teresa, eds.
Clinical Implications of Attachment/ Review of
Vol. 8, No. 4, April 1988, p.23

Bemporad, Sonya
Promoting and Safeguarding Early Relationships in Child Care: The Child Care Dallas Family Day Home System
Vol. 10, No. 3, February 1990, p.10

Bloom-Feshbach, Jonathan and Bloom-Feshbach, Sally and Associates
The Psychology of Separation and Loss/ Review of
Vol. 8, No. 3, June 1988, p.26

Call, Justin, Galenson, Eleanor, and Tyson, Robert, eds.
Frontiers of Infant Psychiatry/Review of
Vol. 3, No. 3, April 1983, p.12

Call, Justin D., Galenson, Eleanor, Tyson, Robert L.
Frontiers of Infant Psychiatry, Vol. II/ Review of
Vol. 6, No. 1, September 1985, p.16

Chess, Stella and Thomas, Alexander
Origins and Evolution of Behavior Disorders from Infancy and Early Adult Life/ Review of
Vol. 5, No. 3, February 1985, p.25

Cohen, Donald and Donnellan, Anne, eds.
Handbook of Autism and Pervasive Developmental Disorders/Review of
Vol. 8, No. 5, June 1988, p.26

Editors
Measuring Depression Through The Use of Specific Criteria: The Raskin Infant Depression Observation Scale
Vol. 3, No. 4, July 1983, p.9

Emde, Robert, ed.
Ken A. Soth: Dialogues from Infancy/ Review of
Vol. 4, No. 5, June 1984, p.13

Fraiberg, Selma
Clinical Studies in Infant Mental Health: The First Year of Life/Review of
Vol. 1, No. 2, December 1980, p.12

Fromm, M. Gerard and Smith, Bruce Lazar
The Facilitating Environment: Clinical Applications of Winnicott's Theory/ Review of
Vol. 10, No. 1, September 1989, p.33

Goldston, Stephen E., ed.
Promoting Mental Health in Early Child Care Settings: Proceedings of the Second Annual UCLA National Conference on Preventive Psychiatry/Review of
Vol. 10, No. 4, April 1990, p.24

Greenspan, Stanley I.
The Development of the Ego: Implications for Personality Theory, Psychopathology, and the Psychoanalytic Process/Review of
Vol. 10, No. 3, February 1990, p.32

Greenspan, Stanley I. and Pollock, George H., eds.
The Course of Life - Volume I: Infancy/ Review of
Vol. 10, No. 2, December 1989, p.27

Greenspan, Stanley I. and Pollock, George H., eds.
The Course of Life - Volume II: Early Childhood/Review of
Vol. 10, No. 3, June 1990, p.27

Greenspan, Stanley; Wieder, Serena; Lieberman, Alicia; Nover, Robert; Lourie, Reginald and Robinson, Mary, eds.
Infants in Multirisk Families: Case Studies in Preventive Intervention/Review of
Vol. 7, No. 4, April 1987, p.19

Greenspan, S.I.
Infancy and Early Childhood: The Practice of Assessment and Intervention with Emotional and Developmental Challenges/ Review of
Vol. 12, No. 1, September 1991, p.32

Herzog, James M.
He Said You'd Think the World Was About to End: Perceptions of and Adaptations to Suffering in Three Preschool Siblings
Vol. 6, No. 3, February 1986, p.6

Horacek, Joseph, H.
Psychotherapy of the Violent Offender: A Reappraisal of Infant Development
Vol. 7, No. 4, April 1987, p.15

Johnston, Kadija
Mental Health Consultation to Day Care Providers: The San Francisco Daycare Consultants Program
Vol. 10, No. 3, February 1990, p.7

Kalmanson, Barbara and Pekarsky, Judith H.
Infant-Parent Psychotherapy with an Autistic Toddler
Vol. 7, No. 3, February 1987, p.1

Kent, James and Friedman, David, eds.
Infant Mental Health: From Theory to Intervention/Review of
Vol. 5, No. 1, September 1984, p.14

Kritzer, Jane
Uncharmed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services/Review of
Vol. 3, No. 3, April 1983, p.14

Kuhrman, A.F.
Bringing Home a Medically Complex Baby: Psychological Issues for Families, Caretakers and Professionals
Vol. 11, No. 2, December 1990, p.36

Kupfersmid, L.
Finding Common Ground: Facilitating a Therapeutic Group for Diverse Parents of Young, Disturbed Children
Vol. 12, No. 3, February 1992, p.22

Landy, S. and Peters, R.D.V.
Understanding and Treating the Hypersensitive Toddler
Vol. 11, No. 3, February 1991, p.22

Lewis, M. and Miller, S.M., eds.
Handbook of Developmental Psychopathology/Review of
Vol. 11, No. 3, February 1991, p.34

Lichtenberg, Joseph
Psychoanalysis and Infant Research/Review of
Vol. 4, No. 2, December 1983, p.16

Mack, John and Ablon, Steven, eds.
The Development and Sustaining of Self-Esteem in Childhood/Review of
Vol. 3, No. 1, September 1984, p.14

Martner, Jan and Magrab, Phyllis, eds.
Mental Health Services for Infants and Toddlers: A Three-State Perspective on the Implementation of Part H of P.L. 99-457/Review of
Vol. 10, No. 3, February 1990, p.33

Massie, Henry and Rosenthal, Judith
Childhood Psychosis in the First Four Years of Life/Review of
Vol. 5, No. 2, December 1984, p.12

Minde, Klaus & Regina
Infant Psychiatry: An Introductory Textbook/Review of
Vol. 6, No. 4, April 1986, p.14

Mintzer, Dorian et al
Parenting an Infant With a Birth Defect: The Regulation of Self-Esteem
Vol. 5, No. 3, June 1985, p.1

Muir, Elisabeth and Tutters, Elizabeth
An Infant Mental Health Training Model for Day Care Professionals: The C.M. Hincks Institute National Day Care Training Project
Vol. 10, No. 3, February 1990, p.12

Murphy, Lois Barclay
When a Child Is Inconsolable: Staying Near
Vol. 9, No. 2, December 1988, p.15

Musick, Judith et al
The Capacity for "Enabling" in Mentally Ill Mothers
Vol. 4, No. 4, April 1984, p.1

National Mental Health Association
The Prevention of Mental-Emotional Disabilities/Review of
Vol. 7, No. 3, February 1987, p.29

Office of Technology Assessment, U.S. Congress
Children's Mental Health: Problems and Services
Vol. 8, No. 1, September 1987, p.26

Pawl, Jeree
Infant Mental Health and Child Abuse and Neglect: Reflections from an Infant Mental Health Practitioner
Vol. 7, No. 4, April 1987, p.1

Pekarsky, Judith
Infant Mental Health Consultation in a Well-Baby Clinic
Vol. 1, No. 4, June 1981, p.6

Provence, Sally
Case Report: A Feeding Problem
Vol. 1, No. 1, September 1980, p.3

Provence, Sally
Case Vignette: Two Depressed Infants
Vol. 3, No. 4, July 1983, p.4

Provence, Sally
Depression in Infancy
Vol. 3, No. 4, July 1983, p.1

Provence, Sally
Helping Young Children Channel Their Aggressive Energies
Vol. 5, No. 4, April 1985, p.13

Provence, Sally
Service-Centered Research in Infant Mental Health
Vol. 3, No. 3, April 1983, p.2

Public Broadcasting System
Right from the Start/Review of
Vol. 4, No. 2, December 1983, p.15

Roberts, Michael and Peterson, Lizette
Prevention of Problems in Childhood: Psychological Research and Applications/Review of
Vol. 5, No. 4, April 1985, p.20

Robertson, James & Joyce
Young Children in Brief Separation/Review of
Vol. 5, No. 2, December 1984, p.13

Rutter, Michael, Tuma, A. Hussain and Lann, Irma, eds.
Assessment and Diagnosis in Child Psychopathology/Review of
Vol. 8, No. 3, June 1988, p.26

Sameroff, Arnold J. and Emde, Robert N., eds.
Relationship Disturbances in Early Childhood/Review of
Vol. 9, No. 5, June 1989, p.

Schrag, Emily
Sensitivities, Skills and Services: Mental Health Roles in the Implementation of Part H of P.L. 99-457/Review of
Vol. 9, No. 1, September 1988, p.29

Shaffer, David, Philips, Irving and Enzer, Norbert B., eds.
Prevention of Mental Disorders, Alcohol and Other Drug Use in Children and Adolescents/Review of
Vol. 10, No. 4, April 1990, p.23

Shanok, R.S.
Parenthood: A Process Marking Identity and Intimacy Capacities
Vol. 11, No. 2, December 1990, p.1

Solnit, Albert
Case Report: Three Homes in Two Years
Vol. 1, No. 2, December 1980, p.4

Stabler, Brian and Underwood, Louis, eds.
Slow Grows the Child: Psychosocial Aspects of Growth Delay
Vol. 8, No. 5, June 1988, p.27

Strain, Phillip S.
Parent Training with Young Autistic Children: A Report on the LEAP Model
Vol. 7, No. 3, February 1987, p.7

Trad, Paul
Infant and Childhood Depression: Developmental Factors/Review of
Vol. 7, No. 5, June 1987, p.33

BEST COPY AVAILABLE

Tronick, Edward A. and Field, Tiffany, eds.
Maternal Depression and Infant Disturbance/Reviews of
Vol. 7, No. 5, June 1987, p.33

Trout, Michael
Working Papers on Process in Infant Mental Health Assessment and Intervention/Reviews of
Vol. 7, No. 3, February 1987, p.29

Verny, Thomas, R., ed.
Pre- and Perinatal Psychology: An Introduction/Reviews of
Vol. 9, No. 2, December 1988, p.25

Walt, Norman et al
Children At Risk for Schizophrenia: A Longitudinal Perspective/Reviews of
Vol. 5, No. 5, June 1985, p.18

Weatherston, Deborah and Tableman, Betty
Infant Mental Health Services: Supporting Competencies/Reducing Risks—A Manual for Community Programs/Reviews of
Vol. 10, No. 1, September 1989, p.34

Werner, Emmy and Smith, Ruth
Vulnerable But Invincible: A Study of Resilient Children/Reviews of
Vol. 2, No. 4, June 1982, p.13

Winnicott, D.W.
Babies and Their Mothers/Reviews of
Vol. 7, No. 5, June 1987, p.32

Zahn-Waxler, Carolyn et al
Young Children of Depressed Parents
Vol. 4, No. 4, April 1984, p.7

PARENTING

Affleck, G., Tennen, H. and Rowe, J.
Infants in Crisis: How Parents Cope with Newborn Intensive Care and Its Aftermath/Reviews of
Vol. 12, No. 3, February 1992, p.37

Als, Hrideliise
Reciprocity and Autonomy: Parenting a Blind Infant
Vol. 5, No. 5, June 1985, p.8

Anthony, E. James and Pollock, George H., eds.
Parental Influences: In Health and Disease/Reviews of
Vol. 6, No. 5, June 1986, p.17

Berman, Phyllis W. and Pederson, Frank A., eds.
Men's Transition to Parenthood: Longitudinal Studies of Early Family Experience/Reviews of
Vol. 9, No. 4, April 1989, p.22

Birns, Beverly and Hay, Dale
The Different Faces of Motherhood/Reviews of
Vol. 9, No. 4, April 1989, p.22

Boukydis, C.F. Zachariah, ed.
Research on Support for Parents and Infants in the Postnatal Period/Reviews of
Vol. 6, No. 3, February 1988, p.28

Brazelton, T. Berry
On Becoming a Family/Reviews of
Vol. 1, No. 3, March 1981, p.15

Brazelton, T. Berry
To Listen to a Child: Understanding the Normal Problems of Growing Up/Reviews of
Vol. 5, No. 2, December 1984, p.13

Brazelton, T. Berry
What Every Baby Knows/Reviews of
Vol. 8, No. 3, February 1988, p.28

Bromwich, Rose M.
"Vulnerable Infants" and "Risky Environments"
Vol. 6, No. 2, December 1985, p.7

Bromwich, Rose
Working with Parents and Infants: An Interactional Approach/Reviews of
Vol. 2, No. 2, December 1981, p.14

Brown, Catherine Caldwell and Gottfried, Allen, eds.
Play Interaction: The Role of Toys and Parental Involvement in Children's Development/Reviews of
Vol. 5, No. 5, June 1985, p.19

Cardone, Ida Anne and Gilkerson, Linda
Family Administered Neonatal Activities: An Innovative Component of Family-Centered Care
Vol. 10, No. 1, September 1989, p.23

Cath, Stanley' Gurwitt, Alan; and Ross, John, eds.
Father and Child: Developmental and Clinical Perspectives/Reviews of
Vol. 4, No. 1, September 1983, p.13

Cena, Susan and Caro, Francis G.
Supporting Families Who Care for Severely Disabled Children at Home: A Public Policy Perspective/Reviews of
Vol. 6, No. 3, February 1986, p.15

Chasnoff, Ira J., ed.
Drug Use in Pregnancy: Mother and Child/Reviews of
Vol. 7, No. 2, December 1986, p.17

Children's Charter of the Courts of Michigan and Michigan Association for Infant Mental Health
Guidelines for Assessing Parenting Capabilities in Child Abuse and Neglect Cases/Reviews of
Vol. 7, No. 4, April 1987, p.23

Comfort, Randy Lee
The Uncommonsense Child: A Book for Parents of Children with Learning Disabilities/Reviews of
Vol. 1, No. 4, June 1981, p.12

Conte, B., Maltz, E. and Solomon, E.
Training and Supporting Leaders of Mother-Baby Groups: The P.A.C.E. Approach
Vol. 11, No. 2, December 1990, p.17

Crockenberg, S.
How Children Learn To Resolve Conflicts in Families
Vol. 12, No. 4, April 1992, p.11

Editors
Program Profile: Family Focus, Inc. Evanston, Illinois
Vol. 1, No. 1, September 1980, p.4

Egeland, B. and Erickson, M.F.
Rising Above the Past: Strategies for Helping New Mothers Break the Cycle of Abuse and Neglect
Vol. 11, No. 2, December 1990, p.29

Falkows, Deborah
A Mother's Work/Reviews of
Vol. 6, No. 3, February 1986, p.14

Frank, Elaine and Rowe, Denise
Preventive Intervention Groups with Adoptive Parents and Their Babies: Minimizing the Risks to Emotional Development in the First Three Years
Vol. 10, No. 5, June 1990, p.

Furman, L.
The "Nursing-Working Dilemma": How Health Professionals can Make a Difference
Vol. 12, No. 5, June 1992, p.36

Galinsky, Ellen
The Six Stages of Parenthood/Reviews of
Vol. 8, No. 1, September 1987, p.28

Galinsky, Ellen and David, Judy
The Preschool Years: Family Strategies That Work—from Experts and Parents/Reviews of
Vol. 9, No. 3, February 1989, p.14

Greenspan, Stanley and Greenspan, Nancy Thorndike
The Essential Partnership: How Parents and Children Can Meet the Emotional Challenges of Infancy and Early Childhood/Reviews of
Vol. 9, No. 5, June 1989, p.26

Johns, N. and Harvey, C., with Glickman-Kind, S.
Stories for the Shelter: Introducing Books for Very Young Children to Parents and Staff
Vol. 12, No. 1, September 1991, p.21

Kirshbaum, Megan
Parents with Disabilities and Their Babies
Vol. 8, No. 5, June 1988, p.8

Klaus, Marshall H. and Phyllis, H.
The Amazing Newborn: Making the Most of the First Weeks of Life/Reviews of
Vol. 6, No. 4, April 1986, p.15

Klinman, Debra and Kohl, Rhana
Fatherhood, U.S.A./Review of
Vol. 5, No. 1, September 1984, p.14

Koherman, A.F.
Bringing Home a Medically Complex Baby: Psychological Issues for Families, Caretakers and Professionals
Vol. 11, No. 2, December 1990, p. 30

Krasnegor, N.A. and Bridges, R.S., eds.
Mammalian Parenting: Biochemical, Neurobiological, and Behavioral Determinants/Review of
Vol. 11, No. 4, April 1991, p.33

Kubicek, Lorraine, F.; Zuskar, Deborah M.; Burns, Kayreen A.; Burns, William J. and Michaels, Gerald Y.
Ethnic Differences in the Transition to Parenthood
Vol. 10, No. 4, April 1990, p.17

Mack, Alison
Toilet Training: The Picture Book Technique for Children and Parents/Review of
Vol. 4, No. 5, June 1984, p.14

McLane, J.B. and McNamee, G.D.
The Beginnings of Literacy
Vol. 12, No. 1, September 1991, p.1.

Mintzer, Dorian et al
Parenting an Infant With a Birth Defect: The Regulation of Self-Esteem
Vol. 5, No. 5, June 1985, p.1

Motion, Inc.
Breastfeeding: A Practical Guide/Review of
Vol. 4, No. 3, February 1984, p.24

Murphy, Lois Barclay; Heider, Grace M. and Small, Colleen T.
Individual Differences in Infants
Vol. 7, No. 2, December 1986, p.1

Musick, J.S.
Adolescents as Mothers: The Being and the Doing
Vol. 11, No. 2, December 1990, p.21

National Center for Clinical Infant Programs
Equals in This Partnership: Parents of Disabled and At-Risk Infants & Toddlers Speak to Professionals/Review of
Vol. 5, No. 5, June 1985, p.16

O'Connel, Lydia
The Unheralded Majority: Contemporary Women as Mothers/Review of
Vol. 5, No. 4, April 1985, p.20

Parks, Stephanie
Help: When the Parent is Handicapped/Review of
Vol. 6, No. 1, September 1985, p.17

Phillips, C.B. and Cooper, R.M.
Cultural Dimensions of Feeding Relationships
Vol. 12, No. 3, June 1992, p.10

Pillemer, K. and McCartney, K., eds.
Parent-Child Relations throughout Life/Review of
Vol. 12, No. 2, December 1991, p.42

Pizzo, Peggy
Parent To Parent: Working Together for Ourselves and Our Children/Review of
Vol. 4, No. 3, February 1984, p.14

Polymorph Films
To Have and Not to Hold: Helping the Parents of Preemie Cope/Review of
Vol. 4, No. 4, April 1984, p.17

Powell, Douglas, R., ed.
Parent Education as Early Childhood Intervention: Emerging Directions in Theory, Research and Practice/Review of
Vol. 9, No. 3, February 1989, p.24

Pruett, Kyle
The Nurturing Father/Review of
Vol. 7, No. 3, February 1987, p.28

Robertson, James & Joyce
Lewis/Review of
Vol. 4, No. 2, December 1983, p.16

Satter, E.
The Feeding Relationship
Vol. 12, No. 3, June 1992, p.1

Segal, Marilyn and Adcock, Dan
Your Child at Play-Birth to One Year, One to Two Years, Two to Three Years/Review of
Vol. 6, No. 1, September 1985, p.16

Sekaer, Christina and Flynn, Virginia
The Infant Care Center as a 'Home' for Parents
Vol. 1, No. 4, June 1981, p.2

Seligman, S.
Using Parenting Programs as a Focus for Intervention
Vol. 11, No. 2, December 1990, p.9

Shanok, R.S.
Parenthood: A Process Marking Identity and Intimacy Capacities
Vol. 11, No. 2, December 1990, p.1

Thoman, Evelyn B. and Browder, Sue
Born Dancing: How Intuitive Parents Understand Their Baby's Unspoken Language and Natural Rhythms/Review of
Vol. 7, No. 3, June 1987, p.32

Thomas, R.B.
Parenting and Professionalism: The Myth of Having It All
Vol. 11, No. 2, December 1990, p.13

Tronick, Edward Z. and Field, Tiffany, eds.
Maternal Depression and Infant Disturbance/Review of
Vol. 7, No. 3, June 1987, p.33

U.S. Department of Agriculture, Food and Nutrition Service
Promoting Breastfeeding: A Guide for Health Professionals Working in the WIC and CSF Programs
Vol. 5, No. 3, February 1985, p.24

U.S. Department of Health and Human Services
Report of the Surgeon General's Workshop on Breastfeeding & Human Lactation/Review of
Vol. 5, No. 3, February 1985, p.25

Winer, M. and Rouse, J.M.
Parents as Teachers: Nurturing Literacy in the Very Young
Vol. 12, No. 1, September 1991, p.23

Winnicott, D.W.
Babies and Their Mothers/Review of
Vol. 7, No. 5, June 1987, p.32

Women's Action Alliance
Beginning Equal: A Manual About Nonsexist Childrearing for Infants and Toddlers/Review of
Vol. 4, No. 3, February 1984, p.13

PREMATURITY

Brigham and Women's Hospital, Boston
Prematurity Years/Review of
Vol. 4, No. 2, December 1983, p.15

Goldberg, Susan and DiVitto, Barbara
Born Too Soon: Preterm Birth and Early Development/Review of
Vol. 3, No. 6, July 1983, p.13

Gottfried, Allen and Gaiter, Juarlyn, eds.
Infant Stress Under Intensive Care: Environmental Neonatology/Review of
Vol. 5, No. 4, April 1985, p.20

Greaves, Stanley N.
The University of Missouri Infant Development Unit and Program
Vol. 4, No. 2, December 1983, p.12

Lopez, Coryl Jones
Early Experiences of Premature Infants and Their Care Providers: Psychodynamic and Environmental Factors in Neonatal Intensive Care
Vol. 4, No. 2, December 1983, p.7

Polymorph Films
To Have and Not to Hold: Helping the Parents of Preemie Cope/Review of
Vol. 4, No. 4, April 1984, p.17

PRENATAL CARE

Boone, Margaret S.
Capital Crime: Black Infant Mortality in America/Review of
Vol. 10, No. 2, December 1989, p.30

National Commission to Prevent Infant Mortality
Home Visiting: Opening Doors for America's Pregnant Women and Children/Review of
Vol. 10, No. 2, December 1989, p.30

Public Health Service
Expert Panel on the Content of Prenatal Care:Caring for Our Future: The Content of Prenatal Care/Review of
Vol. 10, No. 4, April 1990, p.24

Roberson, M.A.
Management in the South Carolina Resource Mothers Program: The Importance of Supervision
Vol. 12, No. 2 December 1991, p.27

Schaaf, M. and Miller, L.
Eating Well While Reading Well: Communicating Useful Nutrition Information
Vol. 12, No. 5, June 1992, p.14

PREVENTION

Bond, Lynne and Wagner, Barry, eds.
Families in Transition: Primary Prevention Programs That Work/Review of
Vol. 8, No. 5, June 1988, p.26

Butler, Owen B.
Preventing Young Children from Failing Is America's Best Investment
Vol. 8, No. 2, December 1987, p.14

Durrenberger, Dave
An Emphasis On Prevention
Vol. 5, No. 4, April 1985, p.15

Farran, Dale C. and McKinney, James, D., eds.
Risk in Intellectual and Psychosocial Development/Review of
Vol. 7, No. 4, April 1987, p.22

Hibbs, Euthymia, ed.
Children and Families: Studies in Prevention and Intervention/Review of
Vol. 8, No. 5, June 1988, p.26

Honig, Alice Sterling, ed.
Risk Factors in Infancy/Review of
Vol. 7, No. 4, April 1987, p.22

Lourie, Reginald S.
The National Center: Primary Prevention in the Earliest Years
Vol. 1, No. 1, September 1980, p.1

National Mental Health Association
The Prevention of Mental/Emotional Disabilities/Review of
Vol. 7, No. 3, February 1987, p.29

Rachel, Annette and Allen, LaRue
Preventing Maladjustment from Infancy Through Adolescence/Review of
Vol. 8, No. 4, April 1988, p.25

Robert, Michael and Peterson, Lizetta
Prevention of Problems in Childhood: Psychological Research and Application/Review of
Vol. 5, No. 4, April 1985, p.20

Select Committee on Children, Youth and Families
Infancy to Adolescence: Opportunities for Success/Review of
Vol. 8, No. 4, April 1988, p.23

Select Committee on Children, Youth and Families
Placing Infants at Risk: Parental Addiction and Disease/Review of
Vol. 7, No. 3, February 1987, p.28

Steinberg, Jane and Silverman, Morton, eds.
Preventing Mental Disorders: A Research Perspective/Review of
Vol. 8, No. 4, April 1988, p.25

Warren, Nancy
The Rural Family Support Project: Community Ownership of Primary Prevention Programs
Vol. 3, No. 3, April, 1983, p.6

PROFESSIONAL RESOURCES

American Academy of Pediatrics and American College of Obstetricians and Gynecologists
Guidelines for Perinatal Care/Review of
Vol. 4, No. 3, April 1984, p.16

American Academy of Pediatrics Committee on the Psychosocial Aspects of Child and Family Health, Morris, Green, ed.
Guidelines for Health Supervision/Review of
Vol. 6, No. 2, December 1985, p.18

Bornstein, Marc and Lamb, Michael, eds.
Developmental Psychology: An Advanced Textbook
Vol. 5, No. 3, February 1985, p.23

Garwood, S. Gray and Fewell, Rebecca, eds.
Educating Handicapped Infants: Issues in Development and Intervention/Review of
Vol. 4, No. 1, September 1983, p.14

Green, Morris and Haggerty, Robert
Ambulatory Pediatrics III/Review of
Vol. 4, No. 4, February 1984, p.16

Greenspan, Stanley
The Clinical Interview of the Child/Review of
Vol. 1, No. 4, June 1981, p.12

Kirkpatrick, Dorothy and Kirkpatrick, Garland
Principles of Developmental Pediatrics in Private Practice: They Work
Vol. 4, No. 5, June 1984, p.5

Lichtenberg, Joseph
Psychoanalysis and Infant Research/Review of
Vol. 4, No. 2, December 1983, p.16

McCrae, Marcia
Medical Perspectives on Brain Damage and Development/Review of
Vol. 3, No. 3, April 1983, p.14

Minde, Klaus & Regina
Infant Psychiatry: An Introductory Textbook/Review of
Vol. 6, No. 4, April 1986, p.16

Rothenberg, B. Annye et al
Parent Making: A Practical Handbook for Teaching Parent Classes About Babies and Toddlers/Review of
Vol. 3, No. 3, April 1983, p.13

Thurston, Swan and Frankenburg, William, eds.
Child Health Communications: Enhancing Interactions Among Professionals, Parents, and Children/Review of
Vol. 4, No. 1, September 1983, p.13

PROFESSIONAL ROLES AND TRAINING

Training Opportunities for Practitioners Working with Infants, Toddlers, and Their Families
Vol. 10, No. 1, September 1989, p.29

Ball, Jean
Reactions to Motherhood: The Role of Post-Natal Care/Review of
Vol. 8, No. 3, February 1988, p.28

Barnard, Kathryn
Maternal and Child Health Nursing: A Perspective on Service, Research and Training
Vol. 2, No. 4, June 1982, p.1

Bash, Deborah Blumenthal and Gold, Winifred Atlas, eds.
The Nurse and the Childbearing Family/Review of
Vol. 2, No. 1, September 1981, p.14

Berman, Carol P. and Collins, Raymond C.
The National Center Fellowship Program: Nurturing New Leaders
Vol. 10, No. 4, April 1990, p.19

Berman, C.P.
Part H Coordinators: Stresses, Satisfactions, and Supports
Vol. 12, No. 3, February 1992, p.13

Bertacchi, Judith and Caplan, Julie
Professional Use of Self in Prevention
Vol. 9, No. 4, April 1989, p.1

Bertaux, J. and Stott, F.M.
A Seminar for Supervisors in Infant/Family Programs: Growing versus Playing More for Staying the Same
Vol. 12, No. 2, December 1991, p.34

Bohlen, Jill K.
Teaching and Learning: My First Year as an Advisor at Wheelock College
Vol. 10, No. 1, September 1989, p.12

Brown, Carole W. and Tharp, Eva K.
Individualizing Training for Early Intervention Practitioners
Vol. 10, No. 1, September 1989, p.8

Coyner, Athleen
Home Visiting by Public Health Nurses: A Vanishing Resource for Families and Children
Vol. 6, No. 1, September 1985, p.1

Coyner, Athleen B.
Home Visiting by Public Health Nurses in Cities and Counties: A Sampler/Resource #
Vol. 6, No. 1, September 1985, p.6

Deneau, Barbara
Preparing Pediatric Residents for the Primary Care of Children with Chronic Illness and Their Families: The Chronic Illness Teaching Program
Vol. 8, No. 3, February 1988, p.7

Fenichel, E.S. and Eggbeer, L.
Preparing Practitioners to Work with Infants, Toddlers and Their Families: Issues and Recommendations/Resource #
Vol. 11, No. 1, September 1990, p.29

Fenichel, Emily Schrag and Eggbeer, Linda
Educating Allies: Issues and Recommendations in the Training of Practitioners to Work with Infants, Toddlers and Their Families
Vol. 10, No. 1, September 1989, p.1

Fenichel, E.
Learning through Supervision and Mentorship To Support the Development of Infants, Toddlers, and Their Families
Vol. 12, No. 2, December 1991, p.1

Fields, B.
Toward Tenacity of Commitment: Understanding and Modifying Institutional Practices and Individual Responses That Impede Work with Multi-Problem Families
Vol. 12, No. 2, December 1991, p.30

Gilkerson, L.
Supports for the Process of Change in "Program Families"
Vol. 12, No. 3, February 1992, p.19

Green, Morris
Training The Pediatrician in the Psychosexual Aspects of Child Health
Vol. 2, No. 4, June 1982, p.5

Greenberg, P.
Character Development: Encouraging Self-Esteem and Self-Discipline in Infants, Toddlers, and Two-Year-Olds/Resource #
Vol. 12, No. 4, April 1992, p.31

Harvey, Catherine and Johns, Nancy
Training Parents for Home Care of Babies Who Have Bronchopulmonary Dysplasia: The Role of the Parenting Specialist
Vol. 8, No. 3, February 1988, p.19

Hoyng, Alice S. and Wittmer, Donna Sasse
Infant/Toddler Caregiving: An Annotated Guide to Media Training Materials/Resource #
Vol. 10, No. 1, September 1989, p.34

Hughes, V.
Working Together for Breastfeeding Success
Vol. 12, No. 5, June 1992, p.32

Ivens, B. and Sweet, N.
Supervision as a Catalyst in the Evolution of an Integrated Infant Mental Health/Developmental Intervention Program
Vol. 12, No. 2, December 1991, p.22

Johns, N. and Harvey, C., with Glickman-Kind, S.
Stories for the Shelter: Introducing Books for Very Young Children to Parents and Staff
Vol. 12, No. 1, September 1991, p.21

Kaplan-Sanoff, Margot; Parker, Steven J. and Zuckerman, Barry
The Child Development Project: A Model of Medical-Educational Collaboration
Vol. 7, No. 5, June 1987, p.18

Krug-Wispe, S.
Pediatric Nutrition Practice Group
Vol. 12, No. 5, June 1992, p.19

LaFarge, Phyllis
Mothers and Pediatricians: Forming a Team
Vol. 4, No. 5, June 1984, p.1

Levy, Bernard
Interview with Bernard Levy
Vol. 1, No. 2, December 1981, p.10

Lynch, E.N. and Hanson, M.J.
Developing Cross-Cultural Competence/Resource #
Vol. 12, No. 4, April 1992, p.32

Mead, D.E.
Effective Supervision: A Task-oriented Model for the Mental Health Professional/Resource #
Vol. 12, No. 2, December 1991, p.41

Miller, Lisa; Rustin, Margaret; Rustin, Michael and Shuttleworth, Judy
Closely Observed Infants/Resource #
Vol. 10, No. 3, February 1990, p.32

Nereneberg, Lucila
Issues of Infants with a Chronic Illness: A Case Study
Vol. 8, No. 3, February 1988, p.11

Neubauer, Peter; Solnit, Albert; and Provence, Sally
Report From the Second Training Institute: Theme and Variations
Vol. 2, No. 3, March 1982, p.2

Pekarsky, J.
Stress from Supervision
Vol. 12, No. 2, December 1991, p.20

Provence, S.A.
Feeding Problems
Vol. 12, No. 5, June 1992, p.18

Pruett, K.D.
Restoring the Players
Vol. 12, No. 2, December 1991, p.7

Robinson, M.A.
Management in the South Carolina Resource Mothers' Program: The Importance of Supervision
Vol. 12, No. 2, December 1991, p.27

Schafer, W.M.
The Professionalization of Early Motherhood
Vol. 12, No. 2, December 1991, p.10

Segal, Marilyn; Leiderman, Roni and Masi, Wendy
Recurring Questions for Family Support Practitioners
Vol. 9, No. 4, April 1989, p.8

Sharrock, R.S.
The Supervisory Relationship: Integrative Resource and Guide
Vol. 12, No. 2, December 1991, p.16

Thomas, R.B.
Parenting and Professionalism: The Myth of Having It All
Vol. 11, No. 2, December 1990, p.13

Thomas, Robin
The Struggle for Control between Families and Health Care Providers When a Child Has Complex Health Care Needs
Vol. 8, No. 3, February 1988, p.15

Warrent, J.C., Reed, C.O., Manker-Seale, S. and Comp, L.A.
CHILDSPACE - Creating an Environment of Respect for Infants and Toddlers and Caregivers of Children
Vol. 12, No. 4, April 1992, p.21

60

Whitebook, Nancy; Pemberton, Carol; Lombardi, Joan; Galinsky, Ellen; Bellon, Dan and Fillinger, Bryn
Raising Salaries: Strategies That Work/ Review of
Vol. 9, No. 2, December 1988, p.24

Wiesler, Serena; Drachman, Robert and DeLeo, Tippie
A Developmental/Relationship Inservice Training Model for Public Health Nurses Serving Multirisk Infants and Families
Vol. 10, No. 1, September 1989, p.16

Woodruff, Geneva; Barnard, Kathryn; Provence, Sally and Pawl, Jeree
Working with Infants, Toddlers and Their Families: What We Do and How We Keep Going
Vol. 7, No. 5, June 1987, p.13

Wyly, M. Virginia and Allen, Jack
Stress and Coping in the Neonatal Intensive Care Unit/Review of
Vol. 10, No. 3, February 1990, p.33

Zeanah, Charles and Carager, Charlene
The Mental Health Professional in the Intensive Care Nursery
Vol. 4, No. 2, December 1983, p.1

PROGRAM EVALUATION

Barnett W. Steven
The Perry Preschool Program and Its Long-Term Benefits: A Benefit-Cost Analysis/ Review of
Vol. 6, No. 4, April 1986, p.16

Bickman, Leonard and Weatherford, David L., eds.
Evaluating Early Intervention Programs for Severely Handicapped Children and Their Families/Review of
Vol. 7, No. 3, February 1987, p.25

Frank, Mary, ed.
Infant Intervention Programs: Truths and Untruths/Review of
Vol. 5, No. 4, April 1985, p.20

Garland et al
Early Intervention for Children with Special Needs and Their Families: Findings & Recommendations/Review of
Vol. 2, No. 3, March 1982, p.14

Greenspan, Stanley and White, Karl
The Efficacy of Prevention Intervention: A Glass Half Full?
Vol. 5, No. 4, April 1985, p.1

High/Scope Press
Changed Lives: The Effects of The Perry Preschool Program on Youths Through Age 19/Review of
Vol. 5, No. 2, December 1984, p.12

Johnson, Robert Wood Foundation
The Perinatal Program: What Has Been Learned?/Review of
Vol. 6, No. 3, February 1986, p.15

Lally, J. Ronald; Mangione, Peter; Honig, Alice and Wittmer, Donna
More Pride, Less Delinquency: Findings from the Ten Year Follow-up Study of the Syracuse University Family Development Research Program
Vol. 8, No. 4, April 1988, p.6

Moran, Mary
Families in Early Intervention: Effects of Program Variables
Vol. 5, No. 5, June 1985, p.11

National Center for Clinical Infant Programs
Program Evaluation: Issues, Strategies and Models/Review of
Vol. 6, No. 4, April 1986, p.14

Rapoport, Robert N.
New Interventions for Children and Youth: Action Research Approaches/Review of
Vol. 9, No. 3, February 1989, p.24

Schweinhart, L.J. and Weikart, D.D.
Young Children Grow Up: The Effects of The Perry Pre-School Program on Youth Through Age 15/Review of
Vol. 1, No. 3, March 1981, p.15

Select Committee on Children, Youth and Families
Opportunities for Success: Update, 1988/ Review of
Vol. 8, No. 5, June 1988, p.23

Shonkoff, Jack; Hauser-Cram, Penny; Krauss, Marty Wyngaarden and Upshur, Carole
A Community of Commitment: Parents, Programs and the Early Intervention Collaborative Study
Vol. 8, No. 5, June 1988, p.1

Slaughter, Diana
Early Intervention and Its Effects on Maternal and Child Development/ Review of
Vol. 4, No. 1, September 1983, p.14

Weider, Serena; Poisson, Susan; Lourie, Reginald and Greenspan, Stanley
Enduring Gains: A Five-Year Follow-Up Report on the Clinical Infant Development Program
Vol. 8, No. 4, April 1988, p.6

Weiss, Heather B.
Evaluating Family Programs/Review of
Vol. 9, No. 3, February 1989, p.24

SERVICE APPROACHES & PROGRAMS

National Directory of Children and Youth Services/Review of
Vol. 8, No. 1, September 1987, p.27

Albee, G.W.; Bond, L.Y. and Monsey, T.V.C., eds.
Improving Children's Lives: Global Perspectives on Prevention/Review of
Vol. 12, No. 4, April 1992, p.34

Anderson, Penny P. and Fenichel, Emily Schrag
Serving Culturally Diverse Families of Infants and Toddlers with Disabilities/ Review of
Vol. 10, No. 2, December 1989, p.27

Anderson, Sheila
The Infant and Toddler Therapeutic Shelter: A Secure Base
Vol. 9, No. 3, February 1989, p.5

Anisfeld, Elizabeth and Pincus, Madeline
The Post-Partum Support Project: Serving Young Mothers and Older Women Through Home Visiting
Vol. 8, No. 1, September 1987, p.13

Badger, Earladeen
United Services for Effective Parenting: A Grass Roots Approach to Child and Family Advocacy
Vol. 2, No. 1, September 1981, p.9

Barker, W.
Empowering Parents - The Evolution, Evaluation and Expansion of a Program
Vol. 11, No. 3, April 1991, p.8

Bayerl, C.T. and Ries, J.D.
EARLY START: Nutrition Services in Early Intervention in Massachusetts
Vol. 12, No. 5, June 1992, p.29

Bender, M. and Baglin, C.A., eds.
Infant and Toddlers: A Resource Guide for Practitioners/Review of
Vol. 12, No. 5, June 1992, p.40

Bennett, T.; Raab, M. and Nelson, D.
The Transition Process for Toddlers with Special Needs and Their Families
Vol. 11, No. 3, February 1991, p.17

Bernstein, Victor J.
Dramatic Responses in a Safe Space: Helping Parents to Reach Difficult Babies
Vol. 9, No. 1, September 1988, p.19

Bonnes, Anthia
Marginally Learning Disabled Young Adults: Competent Caregivers for Infants?
Vol. 4, No. 3, February 1984, p.11

Bovill, Nancy A.
Forming Human Connections in Shelters for Homeless Women and Children
Vol. 9, No. 3, February 1989, p.19

Boyd-Franklin, Nancy
Black Families in Therapy: A Multisystems Approach/Review of
Vol. 10, No. 4, April 1990, p.23

Breakey, G. and Pratt, B.
Healthy Growth for Hawaii's "Healthy Start": Toward a Systematic Statewide Approach to the Prevention of Child Abuse and Neglect
Vol. 11, No. 4, April 1991, p.16

Brunswick, Rose
Working with Parents and Infants: An Interactional Approach
Vol. 2, No. 2, December 1981, p.14

Brown, Catherine Caldwell, ed.
Infants at Risk: Assessment and Intervention/Review of
Vol. 2, No. 1, September 1981, p.13

Bruder, Mary Beth; Wahlquist, Allison and Aunins, Margaret
Parent Education and Infant Monitoring: A Model Demonstration
Vol. 8, No. 3, June 1988, p.16

Burke, Susan H. and Share, Joann
The Family Room
Vol. 7, No. 2, December 1986, p.12

Bush Center for Child Development and Social Policy at Yale University
Programs to Strengthen Families: A Resource Guide/Review of
Vol. 4, No. 2, December 1983, p.16

Cestham, Carol
The Infant Care Program at Evanston Hospital: Putting Research to Work
Vol. 3, No. 2, December 1984, p.1

Cicchetti, Dante and Toth, Sheree
The Application of a Transactional Risk Model to Intervention with Multi-risk Maltreating Families
Vol. 7, No. 3, June 1987, p.1

Conte, B.; Moltz, E. and Solomon, E.
Training and Supporting Leaders of Mother/Baby Groups: The P.A.C.E. Approach
Vol. 11, No. 2, December 1990, p.17

Coyner, Athleen
Home Visiting by Public Health Nurses: A Vanishing Resource for Families and Children
Vol. 6, No. 1, September 1985, p.1

Coyner, Athleen B.
Home Visiting by Public Health Nurses in Cities and Counties: A Sampler
Vol. 6, No. 1, September 1985, p.8

Crocker, A.C.; Cohen, H.J. and Kastner, T.A., eds.
HIV Infection and Developmental Disabilities: A Resource for Service Providers/Review of
Vol. 12, No. 3, February 1992, p.37

Dawson, Peter; Robinson, JoAnn; and Johnson, Caroline
Informal Social Support as an Intervention
Vol. 3, No. 2, December 1982, p.1

Derman-Sparks, Louise and the A.B.C. Task Force
Anti-Bias Curriculum: Tools for Empowering Young Children/Review of
Vol. 10, No. 4, April 1990, p.22

Division of Maternal & Child Health, NCCIP et al
Comprehensive Approaches to Disabled and At-Risk Infants, Toddlers and Their Families/Review of
Vol. 4, No. 5, June 1984, p.9

Dunst, Carl; Trivette, Carol and Deal, Angela
Enabling and Empowering Families: Principles and Guidelines for Practice/Review of
Vol. 8, No. 3, April 1988, p.19

Editors
Frontier Nursing Service: A Demonstration in Family-Centered Primary Health Care
Vol. 4, No. 5, June 1984, p.9

Editors
Program Profile: Child Development Resources, Lightfoot, Virginia
Vol. 1, No. 3, March 1981, p.5

Editors
Program Profile: Family Focus, Inc., Evanston, Illinois
Vol. 1, No. 1, September 1980, p.4

Editors
Program Profile: FIPS, Los Angeles, CA
Vol. 1, No. 2, December 1980, p.6

Egeland, B. and Erickson, M.F.
Rising Above the Past: Strategies for Helping New Mothers Break the Cycle of Abuse and Neglect
Vol. 11, No. 2, December 1990, p.29

Family Resource Coalition
Family Resource Coalition 1982 Program Directory/Review of
Vol. 3, No. 2, December 1982, p.11

Fingley, Carol, ed.
Implementing Early Intervention/Review of
Vol. 9, No. 5, June 1989, p.28

Fitzgerald, K. and Needleman, R.
Reach Out and Read: A Pediatric Program to Support Emergent Literacy
Vol. 12, No. 1, September 1991, p.17

Frank, Mary, ed.
Infant Intervention Programs: Truths and Untruths/Review of
Vol. 5, No. 4, April 1985, p.20

Fraser, D.L.
A Nonverbal Intervention for the Severely Language Disordered Young Child: An Intensive Approach
Vol. 11, No. 1, September 1990, p.23

Freeman, B.L.
Family Literacy: Serving Undereducated Families
Vol. 12, No. 1, September 1991, p.27

Granger, Michele F.; Rosen, Sheri; Yokoyama, Joy and Tasker, Mary
Transitional Group Homes for Children with HIV: Support for Children, Families and Foster Parents
Vol. 9, No. 3, February 1989, p.14

Greenman, Jim
Caring Spaces, Learning Places: Children's Environments That Work/Review of
Vol. 9, No. 2, December 1988, p.24

Greenspan, S.I.
An Intensive Approach to a Toddler with Emotional, Motor, and Language Delays: A Case Report
Vol. 11, No. 1, September 1990, p.20

Greenspan, Stanley
Clinical Illustrations: Mrs. M. and Holly
Vol. 2, No. 2, December 1981, p.8

Greenspan, Stanley; Wieder, Serena; Lieberman, Alicia; Nover, Robert; Lourie, Reginald and Robinson, Mary, eds.
Infants in Multirisk Families: Case Studies in Preventive Intervention/Review of
Vol. 7, No. 4, April 1987, p.19

Gross, R.T. and Haynes, C.
Implementing a Multi-site, Multidisciplinary Clinical Trial: The Infant Health and Development Program
Vol. 11, No. 4, April 1991, p.1

Gunzenhäuser, Nina, ed.
Infant Stimulation: For Whom, What Kind, When and How Much?/Review of
Vol. 6, No. 2, December 1985, p.22

Hardy-Brown, Karen; Miller, Barbara; Dean, Janet; Carranco, Crewson and Thompson, Sherri
Home Based Intervention: Catalyst and Challenge to the Therapeutic Relationship
Vol. 8, No. 1, September 1987, p.8

Hasenstab, M. Suzanne and Horner, John
Comprehensive Intervention with Hearing-Impaired Infants and Preschool Children/Review of
Vol. 4, No. 2, December 1983, p.17

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Healthy Mothers, Healthy Babies Coalition
A Compendium of Program Ideas for Serving Low-Income Women/Review of
Vol. 7, No. 3, February 1987, p.28

Heimlich, Evelyn Phillips
Parentchild Therapy with Adolescent Mothers and Their Children
Vol. 2, No. 3, March 1982, p.12

Intermountain Newborn Intensive Care Center at the University of Utah
Parent-to-Parent/Review of
Vol. 4, No. 2, December 1983, p.15

Isaac, Louise
Early Childhood Intervention
Vol. 3, No. 2, December 1982, p.8

Irvin, B. and Sweet, N.
Supervision as a Catalyst in the Evolution of an Integrated Infant Mental Health/Developmental Intervention Program
Vol. 12, No. 2, December 1991, p.22

Kalmanson, Barbara and Leiberman, Alicia
Case Report: Removing Obstacles to Attachment: Infant-Parent Psychotherapy with an Adolescent Mother and Her Baby
Vol. 3, No. 1, October 1982, p.10

Kaplan-Sanoff, Margot, Parker, Steven J. and Zuckerman, Barry
The Child Development Project: A Model of Medical-Educational Collaboration
Vol. 7, No. 5, June 1987, p.18

Kaufman, M.
Nutrition in Public Health: A Handbook for Developing Programs and Services/Review of
Vol. 12, No. 5, June 1992, p.38

Kirkpatrick, Dorothy and Kirkpatrick, Garland
Principles of Developmental Pediatrics in Private Practice: They Work
Vol. 4, No. 5, June 1984, p.5

Koherman, A.F.
Bringing Home a Medically Complex Baby: Psychological Issues for Families, Caretakers and Professionals
Vol. 11, No. 2, December 1990, p.36

Kyle, John E., ed.
Children, Families and Cities: Programs That Work at the Local Level/Review of
Vol. 9, No. 1, September 1988, p.29

Landy, S. and Peters, R.D.V.
Understanding and Treating the Hypersensitive Toddler
Vol. 11, No. 3, February 1991, p.22

Landy, Sarah
The Effectiveness of Crisis Intervention in Working with a Young Mother and Her Four Pre-School Children
Vol. 7, No. 4, April 1987, p.16

Larner, Mary and Halpern, Robert
Lay Home Visiting Programs: Strengths, Tensions and Challenges
Vol. 8, No. 1, September 1987, p.1

Levine, Carole, ed.
Programs to Strengthen Families: A Resource Guide/Review of
Vol. 9, No. 1, September 1988, p.29

Lieberman, Alicia
Infant-Parent Interaction with Recent Immigrants: Reflections on a Study with Latino Families
Vol. 10, No. 3, February 1990, p.8

Manos, J. and Carty, L.
SSI: New Opportunities for Children with Disabilities/Review of
Vol. 11, No. 4, April 1991, p.32

Martinez, Maurica
The Satellite Clinic: Providing Access to Intervention in Rural Texas
Vol. 6, No. 5, June 1986, p.15

Martinez, Jan and Magrab, Phyllis, eds.
Mental Health Services for Infants and Toddlers: A Three-State Perspective on the Implementation of Part H of P.L. 99-457/Review of
Vol. 10, No. 3, February 1990, p.33

Meisels, Samuel J. and Shonkoff, Jack P., eds.
Handbook of Early Childhood Intervention/Review of
Vol. 10, No. 3, February 1990, p.31

Meisels, S.J.
Early Intervention: A Matter of Context
Vol. 12, No. 3, February 1992, p.1

Moran, Mary
Families in Early Intervention: Effects of Program Variables
Vol. 5, No. 5, June 1985, p.11

National Center for Education in Maternal and Child Health
Reaching Out: A Directory of National Organizations Related to Maternal and Child Health, Third Edition/Review of
Vol. 10, No. 5, June 1990, p.

National Information Center for Children and Youth with Handicaps
A Parent's Guide: Assessing Programs for Infants, Toddlers and Preschoolers with Disabilities/Review of
Vol. 11, No. 4, April 1991, p.32

Nickel, Phyllis Smith and Delaney, Holly
Working with Teen Parents: A Survey of Promising Approaches/Review of
Vol. 5, No. 5, June 1985, p.18

Ortega, Maria Elena and Barnett, Ann B.
Serving the Newest Arrivals: A Model of Early Intervention for Central American Babies and Their Families
Vol. 10, No. 3, February 1990, p.11

Pearce, Ruth and Gallemore, Shelly
A Psychoeducational Approach to Developmental Intervention
Vol. 8, No. 1, September 1987, p.16

Pekarsky, Judith
Infant Mental Health Consultation in a Well-Baby Clinic/Review of
Vol. 1, No. 4, June 1981, p.6

Peterson, Marion L.
The National Directory of Children and Youth Services 1990-91/Review of
Vol. 10, No. 5, June 1990, p.26

Powell, D.R.
Families and Early Childhood Programs/Review of
Vol. 11, No. 1, September 1990, p.29

Preyer, Millie and Greenspan, Stanley
The Toddler Group: A Setting for Adaptive Social/Emotional Development of Disadvantaged One and Two Year Olds in a Peer Group
Vol. 5, No. 4, April 1985, p.6

Project ACCESS
Access to Developmental Services for NICU Graduates: A State-of-the-Art Paper of New England/Review of
Vol. 5, No. 5, June 1985, p.16

Provence, Sally
Infants in Institutions Revisited
Vol. 9, No. 3, February 1989, p.1

Rice, M.L. and Schaefebauch, R.L., eds.
The Teachability of Language/Review of
Vol. 11, No. 1, September 1990, p.29

Roberts, Michael C., Mazeron, Marsella J. and Collier, James
Directory of Hospital Psychosocial Policies and Programs, 1988 Edition/Review of
Vol. 9, No. 5, June 1989, p.27

Rothman, P. and van der Zande, I.
Parent/Toddler Groups: A Model for Effective Intervention to Facilitate Normal Growth and Development/Review of
Vol. 12, No. 2, December 1991, p.40

Schuyler, Valerie and Rushmer, Nancy
Parent-Infant Habilitation: A Comprehensive Approach to Working with Hearing Impaired Infants and Toddlers and Their Families/Review of
Vol. 9, No. 1, September 1988, p.28

Segal, M.M. and Lynch, L.
Replicating Demonstration Projects: A Beginner's Guide
Vol. 11, No. 4, April 1991, p.23

Sekaer, Christina and Flynn, Virginia
The Infant Care Center as a 'Home' for Parents
Vol. 1, No. 4, June 1981, p.2

Seligman, S.
Using Parenting Programs as a Focus for Intervention
Vol. 11, No. 2, December 1990, p.9

Shanok, R.S.
Parenthood: A Process Marking Identity and Intimacy Capacities
Vol. 11, No. 2, December 1990, p.1

Shonkoff, J.P.; Hauser-Cram, P.; Krauss, M.W. and Upshur, C.C.
Early Intervention Collaborative Study: Executive Summary of Findings from Phase One/Review of
Vol. 12, No. 1, September 1991, p.27

Sokoloff, Tracey
Ninety-two years of Public Health Nursing to Mothers, Infants and Children: The Visiting Nurse Service of New York
Vol. 6, No. 1, September 1985, p.10

Trad, P.V.
Interventions with Infants and Parents: The Theory and Practice of Preventive/ Review of
Vol. 12, No. 3, February 1992, p.36

Wachs, T. D. and Gruen, G.
Environmental Stimulation and Early Intervention
Vol. 5, No. 2, December 1984, p.6

Warren, Nancy
The Rural Family Support Project: Community Ownership of Primary Prevention Programs
Vol. 3, No. 3, April 1983, p.6

Wasik, B.H.; Bryant, D.M. and Lyons, C.M.
Home Visiting: Procedures for Helping Families/Review of
Vol. 12, No. 2, December 1991, p.41

Weatherston, Deborah and Tableman, Betty
Infant Mental Health Services: Supporting Competencies/Reducing Risks - A Manual for Community Programs/ Review of
Vol. 10, No. 1, September 1989, p.34

Weissbourd, Bernice
The Family Support Movement: Greater Than The Sum of its Parts
Vol. 4, No. 1, September 1983, p.6

Wender, Serena
Mediating Successful Parenting: Guidelines for Practitioners
Vol. 10, No. 1, September 1989, p.21

Wilson, Linda
Promoting and Strengthening Family Functioning and Maternal Competencies: A Case Study
Vol. 8, No. 3, April 1988, p.19

Young, Paul and Munt, Janet
The Council for Children and Families: A Program of Advocacy in Chittenden County, Vermont
Vol. 2, No. 2, December 1981, p.12

SOCIAL POLICY

Adams, G.C.
Who Knows How Safe? The Status of State Efforts to Ensure Quality Child Care/ Review of
Vol. 11, No. 3, February 1991, p.34

Atkins, Chester
Building A Political Consensus Around Childhood Nutrition
Vol. 5, No. 3, February 1985, p.10

Axel, Helen
Corporations and Families: Changing Practices and Perspectives/Review of
Vol. 6, No. 3, February 1986, p.14

Badger, Earladeen
United Services for Effective Parenting: A Grass Roots Approach to Child and Family Advocacy
Vol. 2, No. 1, September 1981, p.9

Benker, Karen and Rempel, James
Inexcusable Harm: The Effect of Institutionalization on Young Foster Children in New York City/Review of
Vol. 10, No. 1, September 1989, p.35

Bond, J.T.; Galinsky, E.; Lord, M.; Staines, G.L. and Brown, K.R.
Beyond the Parental Leave Debate: The Impact of Laws in Four States/Review of
Vol. 12, No. 1, September 1991, p.31

Boyer, E.L.
Ready To Learn: A Mandate for the Nation/ Review of
Vol. 12, No. 5, June 1992, p.39

Brown, S.S., ed.
Children and Parental Illicit Drug Use: Research, Clinical, and Policy Issues/ Review of
Vol. 11, No. 4, April 1991, p.33

Brown, Wesley
Early Intervention Regulation: Annotation and Analysis of Part H/Review of
Vol. 10, No. 5, June 1990, p.27

Bumpers, Dale
Maternal & Child Health: A Basic Right
Vol. 4, No. 1, September 1983, p.6

Bureau of National Affairs
Work and Family: A Changing Dynamic/ Review of
Vol. 7, No. 1, September 1986, p.18

Bush Institute for Child and Family Policy
Background Papers on State Action to Improve Child Health/Review of
Vol. 3, No. 3, April 1983, p.14

Castle, Michael N.
Focusing on Prevention in the First Sixty Months
Vol. 8, No. 1, September 1987, p.22

Catalyst
Report on a National Study of Parental Leaves/Review of
Vol. 7, No. 1, September 1986, p.18

Cerra, Susan and Caro, Francis G.
Supporting Families Who Care for Severely Disabled Children at Home: A Public Policy Perspective/Review of
Vol. 6, No. 3, February 1986, p.15

Center for the Future of Children
Drug Exposed Infants/Review of
Vol. 11, No. 5, June 1991, p.28

Center for the Study of Social Policy
Kids Count Data Book: State Profiles of Child Well-being/Review of
Vol. 11, No. 5, June 1991, p.28

Cherlin, Andrew J., ed.
The Changing American Family and Public Policy/Review of
Vol. 9, No. 4, April 1989, p.21

Children's Defense Fund
A Children's Defense Budget: An Analysis of the President's Budget and Children/ Review of
Vol. 2, No. 3, March 1982, p.14

Committee for Economic Development, Research and Policy Committee
The Unfinished Agenda: A New Vision for Child Development and Education/ Review of
Vol. 11, No. 4, April 1991, p.31

Durenberg, Dave
An Emphasis on Prevention
Vo. 5, No. 4, April 1985, p.15

Edelman, Marian
Families in Peril: An Agenda for Social Change/Review of
Vol. 7, No. 4, April 1987, p.22

Family Policy Panel, Economic Policy Council of the United Nations Association of the USA
Work and Family Life in the United States: A Policy Initiative/Review of
Vol. 7, No. 1, September 1986, p.18

BEST COPY AVAILABLE

Feinberg, E.A.
The Long Aftermath: Ethical Dilemmas in Resource Allocation Faced by the Care of Medically Fragile Young Children
Vol. 12, No. 3, February 1992, p.27

Fernandez, John P.
Child Care and Corporate Productivity/Review of
Vol. 7, No. 1, September 1986, p.18

Ford Foundation
The Common Good/Review of
Vol. 9, No. 5, June 1989, p.26

Frank, Deborah; Allen, Deborah; and Brown J. Larry
Primary Prevention of Failure to Thrive: Social Policy Implications
Vol. 5, No. 3, February 1985, p.4

Galinsky, Ellen
Investing in Quality Child Care: A Report of AT&T/Review of
Vol. 7, No. 3, February 1987, p.29

Gallagher, James J.; Trohanis, Pascal L. and Clifford, Richard M., eds.
Policy Implementation and P.L. 99-457/Review of
Vol. 9, No. 4, April 1989, p.23

Garwood, S. Gray and Sheehan, Robert
Designing a Comprehensive Early Intervention System: The Challenge of Public Law 99-457/Review of
Vol. 10, No. 1, September 1989, p.34

Gerbner, George et al
Child Abuse: An Agenda for Action/Review of
Vol. 1, No. 2, December 1980, p.12

Gilkerson, Linda; Hilliard, Asa Grant; Schrag, Emily and Shonkoff, Jack P.
Commenting on P.L. 99-457
Vol. 7, No. 3, February 1987, p.13

Grose, C. and Kyle, J.E., eds.
Ways and Means for Children and Families/Review of
Vol. 11, No. 4, April 1991, p.33

Hamburg, D.A.
Today's Children: Creating a Future for a Generation in Crisis/Review of
Vol. 12, No. 5, June 1992, p.30

Harris, Irving B.
Investing in Young Children
Vol. 7, No. 1, September 1986, p.15

Haskins, Ron, ed.
Child Health Policy in an Age of Fiscal Austerity: Critiques of the Select Panel Report/Review of
Vol. 2, No. 4, June 1982, p.12

Hausman, E.B.; Kaufmann, R.K. and Hurth, J.
From Case Management to Service Coordination: Families, Policymaking, and Part H
Vol. 12, No. 3, February 1992, p.10

Hewlett, Sylvia Ann
A Lesser Life: The Myth of Women's Liberation in America/Review of
Vol. 7, No. 1, September 1987, p.18

Joe, Tom et al
The Poor: Profiles of Families in Poverty (A Working Paper)/Review of
Vol. 1, No. 4, June 1981, p.13

Johnson, C.M.; Sum, A.M. and Weill, J.D.
Vanishing Dreams: The Economic Plight of America's Young Families/Review of
Vol. 12, No. 5, June 1992, p.60

Kagan, Sharon and Jeff, Tamar
The Bush Centers in Child Development and Social Policy: Agents for Change
Vol. 1, No. 2, December 1980, p.1

Kamerman, Sheila, B. and Kahn, Alfred J.
Mothers Alone: Strategies for a Time of Change/Review of
Vol. 9, No. 2, December 1988, p.22

Kamerman, Sheila and Hayes, Cheryl, eds.
Families That Work: Children in a Changing World/Review of
Vol. 3, No. 4, July 1983, p.14

Kamerman, Sheila B. and Kahn, Alfred J.
Social Services for Children, Youth and Families in the United States/Review of
Vol. 10, No. 5, June 1990, p.

Kamerman, Sheila B.; Kahn, Alfred J.; Kingston, Paul
Maternity Policies and Working Women/Review of
Vol. 6, No. 4, April 1986, p.16

Kamerman, Sheila B.; Kahn and Kahn, Alfred
The Responsive Workplace: Employers and a Changing Labor Force/Review of
Vol. 8, No. 3, February 1988, p.27

Kamerman, S.B. and Kahn, A.J., eds.
Child Care, Parental Leave, and the Under 3s: Policy Innovation in Europe/Review of
Vol. 12, No. 2, December 1991, p.42

King, Martha P.
Saving Lives and Money: Preventing Low Birthweight/Review of
Vol. 9, No. 2, December 1988, p.23

Knitzer, Jane
Unclaimed Children: The Failure Public Responsibility to Children and Adolescents in Need of Mental Health Services/Review of
Vol. 3, No. 3, April 1983, p.14

Lamb, Michael and Sagi, Abraham, eds.
Fatherhood and Family Policy/Review of
Vol. 4, No. 1, September 1983, p.13

Lazarus, Wendy
Back to Basics: Improving the Health of California's Next Generation/Review of
Vol. 7, No. 5, June 1987, p.32

Lyon, Jeff
Playing God in the Nursery
Vol. 6, No. 5, June 1986, p.18

Maryland Committee for Children
Children, Families and Child Care in Maryland/Review of
Vol. 7, No. 5, June 1987, p.34

McPherson, Merle
Improving Services to Infants and Young Children with Handicapping Conditions and Their Families: The Division of Maternal & Child Health as Collaborator
Vol. 4, No. 1, September 1983, p.1

Miller, George, ed.
Giving Children A Chance: The Case for More Effective National Policies/Review of
Vol. 9, No. 4, April 1989, p.21

Miller, George, Chairman; Coats, Dan, Ranking Minority Member
Opportunities for Success: Cost Effective Programs for Children—a Bipartisan Staff Report of the House Select Committee on Children, Youth And Families/Review of
Vol. 6, No. 1, September 1985, p.17

Morra, L.G.
Children's Issues: A Decade of GAO Reports and Recent Activities/Review of
Vol. 11, No. 4, April 1991, p.32

National Center for Children in Poverty
Five Million Children: A Statistical Profile of Our Poorest Young Citizens/Review of
Vol. 10, No. 5, June 1990, p.

National Center for Clinical Infant Programs
There Ought To Be A Law! Ensuring Statewide Services for Disabled and At-Risk Infants and Toddlers/Review of
Vol. 5, No. 5, June 1985, p.16

National Governors' Association
The First Sixty Months: The Next Steps/Review of
Vol. 8, No. 5, June 1988, p.23

Olmsted, Patricia P. and Weikart, David P., eds.
How Nations Serve Young Children: Profiles of Child Care and Education in 14 Countries/Review of
Vol. 10, No. 4, April 1990, p.23

Orr, Sally and Haskett, George
Parental Leave: Options for Working Parents/Review of
Vol. 5, No. 5, June 1985, p.17

Palmer, John J. and Sawhill, Isabel V.
The Vulnerable/Review of
Vol. 9, No. 4, April 1989, p.21

Palmers, Saro
A Physician's Reflection on Policy Law 94-142/The Education For All Handicapped Children Act) and on its Implications for Health and Mental Health Planning for Infants
Vol. 2, No. 2, December 1981, p.11

Pizzo, Peggy Daly
Whole Babies, Parents and Pizza & Funds: Creating Comprehensive Programs for Infants and Toddlers
Vol. 10, No. 3, February 1990, p.24

Richardson, Gail and Marx, Elizabeth
A Welcome for Every Child: How France Achieves Quality in Child Care/Review of
Vol. 10, No. 4, April 1990, p.23

Schorr, Lisbeth B.
Within Our Reach/Review of
Vol. 8, No. 5, June 1988, p.23

Select Committee on Children, Youth and Families
U.S. Children and Their Families: Current Conditions and Recent Trends, 1987/Review of
Vol. 7, No. 5, June 1987, p.31

Shapiro, Isaac and Greenstein
Holes in the Safety Nets: Poverty Programs and Policies in the States, National Overview/Review of
Vol. 9, No. 2, December 1988, p.22

Sidel, Ruth
Women and Children Last: The Plight of Poor Women in Affluent America/Review of
Vol. 7, No. 1, September 1986, p.18

Silver Ribbon Panel
Head Start: The Nation's Pride, A Nation's Challenge/Review of
Vol. 11, No. 1, September 1990, p.30

Smith, S.; Blank, S. and Bond, J.T.
One Program, Two Generations: A Report of the Forum on Children and the Family Support Act/Review of
Vol. 11, No. 1, September 1990, p.30

Smith, S.; Blank, S. and Collins, R.
Pathways to Self-Sufficiency for Two Generations/Review of
Vol. 12, No. 3, June 1992, p.40

Steglin, D.A., ed.
Early Childhood Education: Policy Issues for the 1990s/Review of
Vol. 12, No. 3, June 1992, p.39

Thompson, T. and Hupp, S.C., eds.
Saving Children At Risk: Poverty and Disabilities/Review of
Vol. 12, No. 3, February 1992, p.37

Weir, Robert F.
Selective Nontreatment of Handicapped Newborns/Review of
Vol. 6, No. 4, April 1986, p.16

Weintraub, Frederick K., Ramirez, Bruce
Progress in the Education of the Handicapped and Analysis of P.L. 99-199/Review of
Vol. 5, No. 5, June 1985, p.17

Whitebook, Marcy; Howes, Carollee, and Phillips, Deborah
Who Cares? Child Care Teachers and the Quality of Care in America/Review of
Vol. 10, No. 2, December 1989, p.27

Wilson, Ann
Thoughts Following a Congressional Fellowship
Vol. 3, No. 4, April 1983, p.12

Wittmer, Donna S.
Model Versus Model Child Care for Children from Low-Income Families
Vol. 7, No. 1, September 1986, p.8

Yogman, Michael W. and Brazelton, T. Berry
In Support of Families/Review of
Vol. 7, No. 5, June 1987, p.31

Young, Paul and Munt, Janet
The Council for Children and Families: A Program of Advocacy in Chittenden County
Vol. 2, No. 2, December 1981, p.12

Zigler, E.F. and Lang, M.E.
Child Care Choices: Balancing the Needs of Children, Families and Society/Review of
Vol. 11, No. 4, April 1991, p.31

Zigler, E.
What Is the Case for a National Infant Care Leave Policy?
Vol. 11, No. 5, June 1991, p.24

Zigler, Edward; Kagan, Sharon Lynn; and Klugman, Edgar, eds.
Children, Families and Government: Perspectives on American Social Policy/Review of
Vol. 4, No. 3, February 1984, p.14

Zigler, Edward and Frank, Meryl, eds.
The Parental Leave Crisis: Toward a National Policy/Review of
Vol. 8, No. 4, April 1988, p.24

Zinsser, Caroline
Born and Raised in East Urban: A Community Study of Informal and Unregulated Child Care/Review of
Vol. 10, No. 4, April 1990, p.22

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